FISCAL YEAR 1988 BUDGET RECONCILIATION ISSUES RELATING TO PAYMENT OF RADIOLOGISTS, ANESTHESIOLOGISTS, AND PATHOLOGISTS ON THE BASIS OF DIAGNOSIS RELATED GROUPS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

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FISCAL YEAR 1988 BUDGET RECONCILIATION ISSUES RELATING TO PAYMENT OF RADIOLOGISTS, ANESTHESIOLOGISTS, AND PATHOLOGISTS ON THE BASIS OF DIAGNOSIS RELATED GROUPS

WEDNESDAY, MAY 13, 1987

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 1:39 p.m., in room B-318, Rayburn House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
TUESDAY, MAY 5, 1987

PRESS RELEASE #14
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON FISCAL YEAR 1988 BUDGET RECONCILIATION ISSUES RELATING TO PAYMENT OF RADIOLOGISTS, ANESTHESIOLOGISTS, AND PATHOLOGISTS ON THE BASIS OF DIAGNOSIS RELATED GROUPS TO BE HELD ON WEDNESDAY, MAY 13, 1987

The Honorable Fortney H. (Pete) Stark (D. Calif.), Chairman of the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on payment of radiologists, anesthesiologists, and pathologists (RAPs) on the basis of diagnosis related groups (DRGs). The hearing will be held on Wednesday, May 13, 1987, beginning at 1:30 p.m., in room B-318 Rayburn House Office Building.

In announcing the hearing, Chairman Stark said, "Current methods of payment for RAPs are unsatisfactory. RAP fees are too high, and there is no effective control on the volume of RAP services paid for by Medicare. Paying RAPs on the basis of the DRGs would solve these problems.

"RAPs should also be required to take assignment on Medicare claims. Hospital patients have no opportunity to select a RAP physician who will accept assignment. So, fairness argues that RAPs shouldn't be able to charge more than the Medicare-approved fee."

The purpose of the May 13 hearing is to consider DRG-based payment for RAPs. Other issues such as assignment and fee schedules will also be considered.

Oral testimony will be heard from <u>invited witnesses only</u>. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

Background

In January, a recommendation to pay RAPs on the basis of the DRGs was included in the President's fiscal year 1988 budget proposal. The Congressional Budget Office has stated that a DRG-payment policy could save up to $1.2 billion over the next five years.

Several factors make DRG-based payment appropriate for RAPs. At many hospitals, there is only one RAP physician group practice providing services, and RAP groups often have exclusive service contracts with hospitals. Furthermore, patients generally have little opportunity to select a RAP physician. As a result, there is little downward pressure on RAP fees.

DRG-based payment would also help provide important incentives for efficiency. Currently, there are no effective controls on utilization of RAP services. Use of radiology services, in particular, has been increasing at a rapid rate.

A number of important issues have been raised regarding DRG-based payment. These include the distributional impact of DRG payment and potential impact on quality of care. Important aspects of a DRG proposal also need to be specified.

Studies by the General Accounting Office and by the Congressional Research Service will be presented to the Subcommittee at the May 13 hearing. The Department of Health and Human Services also is conducting a Congressionally-mandated study of the RAP-DRG proposal. This report is to be submitted to Congress by July 1, 1987. Preliminary results will be presented at the hearing.

WRITTEN STATEMENT IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, May 29, 1987, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE ENCLOSED FORMATTING REQUIREMENTS

* * * * *

Chairman STARK. The Subcommittee on Health of the Committee on Ways and Means will begin.

Go ahead and give your opening statement first.

Mr. GRADISON. Mr. Chairman, earlier this year I made the mistake, I guess it was a mistake, of indicating I had an open mind on the RAP issue. As I have said to some of those who are present in the hearing room, hardly a day has passed that I have not had the good fortune to spend a portion of it with people who happen to be radiologists, anesthesiologists and pathologists, either here in Washington or back in River City.

Mr. Chairman, there are a number of problems in the current system of paying physicians. These include inequities in the fees between cognitive and procedural services, geographic inequities, low fees for rural physicians and beneficiary liability for balanced billing on unassigned claims.

Congress has developed strategies to address some of these issues. The development of the relative value scale and the participating physician program offer great hope.

The major problem with part B facing the Federal Government as payer, remains unresolved. That problem is the growth in the use of physician services. The numbers are sobering. In the 5-year period between 1983 and 1988, payments to physicians will nearly double from $12.7 to $23.8 billion. This increase will occur despite the fact that Medicare physician fees were frozen for 30 months of this period.

The future does not look any better. The Congressional Budget Office expects 12-percent-average growth for Medicare physician payments over the next 4 years. CBO attributes 43 percent of this growth to increases in the volume of services provided. The remainder of the increases is due to inflation and the cost of doing business and the expanded elderly population.

These factors are understandable, but continued extraordinary growth in volume is the issue that I want to call attention to because I think it, at some point, has to be dealt with.

We have learned from our experience with hospitals and DRGs that more care is not necessarily better care. Unfortunately, we have no comparable payment vehicle to encourage physicians to practice more efficiently. Accomplishing this task should be our goal for part B.

I want to thank my chairman, Mr. Stark, for holding this hearing today on the RAP issue. I have concerns about paying RAPs under a DRG scheme because RAPs do not control the ordering of procedures or tests. Therefore, I must admit that I am doubtful that the committee has enough information to justify action at this time on the RAP proposal.

However, I do feel strongly that today's discussion will be useful in focusing the attention of this subcommittee in the Congress on the volume question. It is also my view that the Physician Payment Review Commission should place the part B volume issue at the forefront of its agenda, as should the Department of Health and Human Services.

I hope, Mr. Chairman, that it will be possible for us to explore the possibility of jointly sending a letter to the Commission asking it to make the volume question a top priority.

Mr. Chairman, I think it is time to stop saying that the volume problem is impossible to resolve and it is time to roll up our sleeves and pursue payment reform for part B as seriously as we have done in the past for hospitals.

Thank you, Mr. Chairman.

Chairman STARK. Thank you, Mr. Gradison. You just made it unnecessary for me to read this long and detailed statement.

I suspect there are some differences and additional comments that I would like to highlight. It is the opinion of the Chair that the current methods of payments for the RAP are unsatisfactory. I am also disposed to think that the fees are too high and that there is no control on the volume, as you have indicated.

One method of solving this would be to pay on the basis of the DRGs. In many hospitals, there is only one RAP physician group practice providing services. The groups often have exclusive service contracts and patients generally have little opportunity to suggest a RAP physician. As a result, there is little downward pressure or market pressure on RAP fees.

It is clear that the average earnings of the RAPs greatly exceeds the average earnings of all physicians and those higher earnings cannot necessarily be explained on the basis of greater training or manpower shortages.

There are some incentives for efficiency under the DRG system. Whether those are the best incentives, in reimbursing RAPs or not, is a question.

The major problem of beneficiary protection comes from the problem of extra billing on unassigned claims. That could easily be resolved if the payment was made directly to the hospital.

In my opinion, the RAPs should be required to take assignment. As a practical matter, hospital patients have little or no opportunity to select a RAP who will accept assignment. Therefore, fairness would argue that the RAP should not be able to charge more than the Medicare approved fee.

Although the assignment rates are relatively high, anesthesiologists accept assignment on only about 44 percent of their claims. There is really no excuse for low assignment rates. The RAPs are well compensated by Medicare and if you compare their RAP services to payments for primary care physicians, the RAPs appear to be overly generously paid.

The AMA has launched an all-out campaign against the DRG proposal. I hope that they are as successful in this political endeavor as they have been on others in the past. [Laughter.]

It has urged support for a resolution that urges Congress to delay consideration of the DRG proposal until 1989 when Congress receives a report on paying physicians on the basis of a relative value scale. While I support the relative value scale study, it is important to stress that the study is not relevant to the issue of paying RAPs on the basis of DRGs.

Today we will hear reports on payments of RAPs by the General Accounting Office, by the Congressional Research Service. We will also hear preliminary results from a congressionally mandated study of DRGs for RAPs. This mandated study will be submitted to Congress by July 1.

In my opinion, we will then have more than enough information to make a sound decision. Whether, in a political context, we have the votes or not, to me, will depend somewhat on the evidence that unfolds in the next couple of months.

With that, I would like to ask unanimous consent that the prepared statements of the members and the witnesses today will appear in the record in their entirety and that the record will remain open a day or two for people to submit questions in writing and the answers thereto.

[The statement of Chairman Stark follows:]

HON. FORTNEY H. (PETE) STARK, CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, HEARING ON PAYMENT OF RADIOLOGISTS, ANESTHESIOLOGISTS, AND PATHOLOGISTS ON THE BASIS OF DIAGNOSIS RELATED GROUPS

During the past 4 years, it has become increasingly clear that payment for physicians' services under Medicare part B is in need of reform. Despite a variety of cost control measures, payments to physicians have increased at a rapid rate. Even during the 1984–1986 physician fee freeze, outlays increased at a rate of 8 percent per year, primarily due to increases in the volume of services provided on a per enrollee basis.

Costs for the elderly are also increasing. Under current law, physicians have the option of refusing assignment and charging more than the Medicare approved fee. During 1987, extra charges on Part B services will total more than $3 billion. More than 700,000 elderly will incur extra charges in excess of $1,000.

One promising step to control costs and protect the elderly is to pay radiologists, anesthesiologists, and pathologists on the basis of diagnosis related groups. This approach was first suggested to the Subcommittee by several health policy experts at a hearing last year.

This year, a proposal to pay RAPs on the basis of the DRGs was included in the President's fiscal year 1988 budget proposal. The Congressional Budget Office has stated that a DRG payment policy could save up to $1.2 billion over the next five years.

Current methods of payment for RAPs are unsatisfactory. RAP fees are too high, and there is no effective control on the volume of RAP services paid for by Medicare. Paying RAPs on the basis of the DRGs would solve these problems.

Several factors make DRG-based payment appropriate for RAPs. At many hospitals, there is only one RAP physician group practice providing services, and RAP groups often have exclusive service contracts with hospitals. Furthermore, patients generally have little opportunity to select a RAP physician. As a result, there is little downward pressure on RAP fees.

During 1985, the average physician earned $113,200 after expenses. In comparison, radiologists earned $150,800, anesthesiologists earned $140,200, and pathologists earned $127,000. These higher earnings cannot be explained on the basis of greater training or manpower shortages.

Paying RAPs on the basis of DRGs would help get fees under control. Payments would be limited to the DRG allowance.

DRG-based payment would also provide important incentives for efficiency. Currently, there are no effective controls on utilization of RAP services. Use of radiology services, in particular, has been increasing at a rapid rate.

Finally, the problem of extra billing on unassigned claims for RAP services could be easily resolved if payment is made directly to the hospital.

RAPs should be required to take assignment. As a practical matter, hospital patients have no opportunity to select a RAP physician who will accept assignment. So, fairness argues that RAPs shouldn't be able to charge more than the Medicare-approved fee.

Although assignment rates for radiologists and pathologists are relatively high, anesthesiologists accept assignment on only 44 percent of claims.

There is no excuse for low assignment rates among RAPs. RAPs are well compensated by Medicare. Indeed, if one compares payments for RAP services to payments for primary care physicians, RAPs are clearly overpaid.

The American Medical Association has launched an all out campaign against the DRG proposal. It has urged support for a resolution that urges Congress to delay consideration of the DRG proposal until 1989 when Congress receives a report on paying physicians on the basis of a relative value scale.

While I support the relative value scale study, it is important to stress that the study is not relevant to the issue of paying RAPs on the basis of DRGs.

Today, we will hear reports on payment of RAPs by the General Accounting Office and by the Congressional Research Service. We will also hear preliminary results from a Congressionally mandated study of DRGs for RAPs. This mandated study will be submitted to Congress by July 1.

We will have more than enough information to make a sound decision, if we have the political will to examine the evidence.

Chairman STARK. With the exception of the administration, we will ask the witnesses to try and summarize or expand on their remarks within the suggested 5-minute time limit. We will ask members also, on the first round of questioning, to hold their questioning to 5 minutes with the understanding we will keep going around as long as people want to ask questions.

With that, I would call—unless any of the other members have a statement, I would call our first witness, Dr. Ross Anthony, Associate Administrator for Policy of Health Care Financing Administration.

Welcome back to the committee, Dr. Anthony, and will you proceed to enlighten us in any manner you are comfortable.

STATEMENT OF C. ROSS ANTHONY, PH.D., ASSOCIATE ADMINISTRATOR FOR PROGRAM DEVELOPMENT, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. ANTHONY. Thank you. It is a pleasure indeed to be back again, and before I start my statement on the payment of radiologists, anesthesiologists, and pathologists, I would just like to indicate that last week when I spoke about capital, I indicated that our regulation on this issue would be soon going to the Federal Register. I am glad to be able to tell you that either this afternoon or tomorrow morning, that regulation will be forwarded to the Federal Register and will be published in the very near future.

Of course, we will be providing you all with copies and I will be glad to answer any questions that you might have on that issue.

Chairman STARK. Thank you.

Mr. ANTHONY. Today I am here to discuss Medicare payments for radiology, anesthesiology and pathology services provided to hospital inpatients by physicians. These services are sometimes referred to as RAP services.

MEDICARE PAYMENT FOR PHYSICIAN SERVICES

Medicare currently pays physicians for the reasonable charges of covered services they deliver to Medicare patients. The methodology used to determine these charges is confusing, inherently inflationary and, at times, inequitable. The system not only lacks incentives for cost efficiency, but it rewards the overprovision of medical services. For example, under a congressionally imposed 2-year freeze on payments for physician services, Medicare physician spending actually grew by 10.5 percent between 1985 and 1986. Many physicians responded to the charge limit by either increasing the volume and intensity of services provided or by increasing billings for the same level of services.

Medicare expenditures for all physicians' services increased 137 percent between 1980 and 1986, despite a 30-month freeze during

this period. Efforts to reform payments for physicians' services have proven difficult. This administration believes the answer to physician payment reform in the long run is to prepay the entire Medicare benefit package to an entity that will manage care. Our private health plan option is one example of such a system.

Such an approach will encourage efficient delivery of services by dealing with both price and volume, maintain quality and ensure that decisions are made at the appropriate levels. However, for the shorter term, we believe we can take significant steps to improve the Medicare physician payment system.

PAYMENT FOR RADIOLOGY, ANESTHESIOLOGY, AND PATHOLOGY SERVICES

In 1986, over 15 percent of Medicare's inpatient physician expenditures, or almost $2 billion, was paid for RAP services delivered by physicians in hospitals. Physicians specializing in radiology, anesthesiology and pathology services practice primarily in hospitals. Over 79 percent of their income and the majority of their services are provided in the hospital. In addition, physicians who specialize in providing RAP services frequently have some type of financial arrangement with a hospital. While patients usually select their own physicians, they generally do not select physicians who provide RAP services. RAP services are usually provided upon the referral of an attending physician or through the hospital staffing arrangement.

Although it does not extend to physicians' services for hospital inpatients, Medicare's hospital prospective payment system has proven effective in controlling costs and providing incentives for the delivery of appropriate services. The prospective payment DRG classification has been demonstrated to relate patients' diagnoses with resource consumption. Using DRGs as a point of departure, our RAP proposal would take allowable charges for all inpatient RAP services and determine the average price for the average package of RAP services for each DRG.

We estimate that our RAP reform proposal, beginning July 1988, will save $660 million over 5 years through the creation of incentives for the more efficient use of resources and the elimination of excess services.

We have not finalized our RAP proposal. There are a number of complex design questions and issues. These include how to and whom to pay; what billing and assignment provisions would apply; and what services should be included in the bundled payment. These decisions have different effects on Medicare administrative costs, hospitals, beneficiary cost-sharing amounts, and physician income and autonomy.

There are two basic options, however.

One option would be to incorporate the payment for RAP services into the DRG rate and pay the hospital. This approach would entail changing most payment rules affecting physicians, such as assignment and billing beneficiaries. In addition, numerous individual physicians and physician groups indicated deep concern about folding their payments into hospital payments.

The second option, which may be preferable, is to make the RAP payment to physicians. We would be designing this payment

system specifically for RAP services. For example, update factors could be tailored to reflect changes in RAP services rather than adopting or modifying the PPS market basket and update system. Hospitals and physicians could maintain independent relationships and physicians could continue to balance-bill, that is, charge patients more than the Medicare approved amount, on a limited basis. We intend that beneficiaries would have at least as much protection as under the MAAC, maximum allowable actual charge, limits.

Our proposal would not reduce necessary services. Rather, we intend to accomplish savings by encouraging more efficient delivery of services. We will continue to monitor the process to assure that services meet quality of care standards, a key consideration from our perspective. Other goals are to provide incentives for physician efficiency; permit reasonable administration of the system; assure beneficiary access to services; and design a system that minimizes disruptive changes to existing physician billing and assignment options. We continue to oppose mandatory assignment.

RESEARCH

The Omnibus Budget Reconciliation Act of 1986 directed the Department to study the design and implementation of a prospective payment system for RAP services furnished to hospitals that was mentioned earlier. Our report is in the review stage and should be submitted on schedule, due July 1.

Research studies are being conducted and we expect the findings will assist us as we continue to refine the technical issues related to implementing our proposal. One of the contractors, Dr. Janet Mitchell from the Center for Health Economics Research, will report on some of our research activity later this afternoon. We actually received this material last week.

CONCLUSION

The Medicare prospective payment system for hospitals now provides incentives for cost-efficient and quality care in the appropriate setting. A separate prospective payment system for RAP services provided by physicians to hospital inpatients would extend parallel incentives to all RAP procedures performed during a hospital admission. Our proposal is in the final stage of review. A reformed payment system for RAP services based on an average prospective price will result in cost savings to Medicare; more appropriate treatment for the patient; and a more rational payment system.

I would be glad to answer any questions you may have for me.

Chairman STARK. Thank you very much.

Why should not any proposal that we consider, or that you submit, apply to outpatient services as well as inpatient at ambulatory surgical centers?

Mr. ANTHONY. You mean as relates just to the RAP physicians?

Chairman STARK. Yes.

Mr. ANTHONY. There has been a discussion about, for instance, putting in service windows or trying to some way deal with this in a broader perspective with the fear that if we put in a RAP system

just for hospital services, that there might be some incentives to take those services out of the hospital.

In actual fact, we do not find there will be probably any real problem with either pathology or anesthesiology and the biggest concern would be that radiology might have that type of incentive. There really are a couple of reasons why we have considered not doing that, although we looked at the issue closely.

One is just the administrative impossibility of trying to track when, in fact, the service is provided.

Chairman STARK. That would not be the case in ambulatory surgical centers, though, would it?

Mr. ANTHONY. No.

Chairman STARK. So you could do it there?

Mr. ANTHONY. We could do it, if we really wanted to. I think the other thing that you want to consider, though, is to the degree that this might have incentives to have services moved out of the hospital and into the ambulatory setting that, from our perspective, is a good thing. We would like to see that service is moved out as much as possible.

Chairman STARK. But you might stick it to the beneficiary that way. In other words, you cannot extra bill on the ambulatory service charge, but you can extra bill fare-thee-well all you want on the RAP fees, so you cut the fee to the hospital from $1,000 to $500 in ambulatory surgery and then let them add, on a $500 extra billing, and it all gets loaded on the beneficiary.

Mr. ANTHONY. If we are talking about hospital services, those are all under the part A DRG system, so it really is a separate issue there.

Chairman STARK. But what I am saying is those same services, many of them, can be provided in an ambulatory surgical setting. So why should a guy not be able to extra bill or get a fixed rate in the hospital, go and do the same procedure at an ambulatory surgical center and be able to extra bill or charge fee for service? It does not make any sense, does it?

Mr. ANTHONY. Right now, if we are talking about a physician, he can extra bill in either location.

Chairman STARK. Okay, but if we are going to restrict the payment in a hospital to that physician, what rationale would there be in allowing that same physician to just go into the same kind of an operating room that is detached from the hospital and charge twice as much?

Mr. ANTHONY. In actual fact, as I indicated, there are a number of different ways——

Chairman STARK. That does not make any sense, does it, to do that?

Mr. ANTHONY. If you design systems that way, then I can see the problem that you are indicating. In actual fact we, as I indicated, have opposed mandatory assignment and have not, at this point, designed a system that would be of that nature.

Chairman STARK. It is not even mandatory assignment. If you are going to design a system for DRGs or some other payment fee for RAPs, do you want that only to take place when they practice on the second floor, but not on the first floor? What I am saying is

would you not then want, wherever they performed that procedure, for the fee to be the same, if Medicare is saving money?

Mr. ANTHONY. I think that we would be willing to look at that, but I think what you are moving toward is an all-DRG system for all physicians, which we——

Chairman STARK. That is your guys idea, not mine. Let us just go through this slowly. Let us take cataract surgery. You are going to limit what the RAPs can charge for a cataract surgical procedure on an in-patient setting, correct?

Mr. ANTHONY. We are going to set up a DRG system.

Chairman STARK. That is what you are suggesting, some kind of a fee limit or cost limit to Medicare. That same procedure, that same RAP can do the same procedure in an ambulatory surgical setting. You are not going to control the fees they charge there?

Mr. ANTHONY. We are talking about two entirely different systems, but as our current proposal would apply only to inpatient hospital services.

Chairman STARK. Now, does it make any sense, where you are doing the same service to the same patient, to charge one fee in the hospital and another fee in the ambulatory service center?

Mr. ANTHONY. I think if you had exactly the same thing, what you are talking about, I can see your point. But if we are talking about the exact same——

Chairman STARK. We are talking about the exact same procedure, in the exact same room, only one room is attached to a hospital and another room is 200 yards away, with a separate parking lot. Now why should the fee to the person performing the professional service be any different?

Mr. ANTHONY. I would be glad to look at that. I am not sure I understand.

Chairman STARK. I assume the question is clear. Doctor, just in your opinion——

Mr. ANTHONY. Excuse me, I am sorry.

Chairman STARK. Tell me why that——

Mr. ANTHONY. We would be glad to look at that, if that is what you would like us to do. We would be glad to look at it further.

Chairman STARK. I would just like you to think, not look. Tell me what could be wrong, if we are talking about limiting these fees. What I am suggesting is there is a loophole. The most prevalent and expensive procedure we are paying for is cataract surgery, is it not?

Mr. ANTHONY. It is one of them.

Chairman STARK. All you have to do is suddenly hang out a sign that says this is ambulatory. You do not change a thing. I am suggesting to you that we might get handed our lunch and gamed once again by those guys, who are thinking how to steal our money, while we are not thinking enough about how to keep it for the taxpayers.

This whole idea of DRGs, just to get the record straight, was dreamed up by whom? DRGs for RAPs. OMB? When did it occur and where?

Mr. ANTHONY. There has been a lot of discussion; the actual idea has been around now for a couple of years. I am actually not sure who is the originator of the idea.

Chairman STARK. Who is pushing it now, OMB or HCFA?

Mr. ANTHONY. The administration considers their budget every year and during the budget negotiations we agreed, as the administration, that one of the physician proposals we put forward would be this RAPs initiative. So the administration, at this point in time, is proposing a RAP, DRG system.

Chairman STARK. So you did not get the idea from Congress, is that correct?

Mr. ANTHONY. That is correct.

Chairman STARK. I just wanted to get that on the record. [Laughter.]

Why do you not now have authority to do what you would like to do by regulation?

Mr. ANTHONY. I am told that we actually do not have that authority because these types of fundamental changes would require changes, in the very least in the way we handle co-insurance and premium amounts. All of those issues really need to go through the Congress for legislative authority to make those changes.

Chairman STARK. It is not even a close call?

Mr. ANTHONY. I do not believe so. I mean, the present system requires that we pay on a reasonable charge basis and this would be really a fundamental departure from that and one reason that we are proposing it.

Chairman STARK. Do you have a dollar savings in mind, no? What is your target?

Mr. ANTHONY. The 5-year projections are for savings of $660 million.

Chairman STARK. Per year or for a 5-year total?

Mr. ANTHONY. That is a 5-year total. Let me break it down for you. It breaks down to, in 1988, $10 million—these are all savings numbers—1989 it is $50 million; 1990, $120 million; 1991, $190 million; and 1992, $290 million.

Chairman STARK. When would you guess that you will submit a formal proposal to us?

Mr. ANTHONY. The legislation is presently in the review process and it is my anticipation within the next few weeks or month or so that that legislation would be submitted to Congress. The RAPs proposal is part of the overall administration legislative package, so it becomes a quite lengthy document and needs to go through a lot of the clearance process.

Chairman STARK. And that is relative to meeting our budget reconciliation?

Mr. ANTHONY. That is correct.

Chairman STARK. You are keeping an eagle eye on our schedule, when we have to get this information?

Mr. ANTHONY. I realize that, under ideal circumstances, you would have the legislation already and we are working to see that you get it as soon as possible.

Chairman STARK. Can you give us a hint as to what the odds are that it will be a payment to the physician or payment to the hospital, or is there any discussion on alternate or a combination plan?

Mr. ANTHONY. We have tried to keep our options open as we have gone through the process. I guess one reason for that, very simply, is that the data and the information are just coming in. So

we are trying to keep some flexibility so we can make the right kinds of decisions that are appropriate.

As I indicated in my testimony, our preference is at least at this time given what we know, to move towards the second system, the so-called paying the physician or the RAPs group.

Chairman STARK. You alluded, in your testimony, to extra billing and that you are saying that they could continue to balance bill, but you are also going to protect the beneficiaries?

Mr. ANTHONY. Yes, sir.

Chairman STARK. That is enough of a speculation to suggest to me that you maybe have an idea what you have got in mind for that. What kind of limits do you plan to place on balanced billing?

Mr. ANTHONY. We think that there ought to be some limits on balance billing, at the very least to maintain some equity between the so-called MAAC limits that are presently on all physician actual charges and nonparticipating physicians.

OBRA had ways of dealing with this and we are looking at the possibility of some type of OBRA limits to be sure that, in fact, beneficiaries are protected. I think it is also important to indicate that the savings attached to this also partly will result in savings to beneficiaries who will not have co-pays or deductibles attached to this.

Also, it is important to realize that they will also benefit from increased efficiency to the extent that tests might not be ordered or other things might not happen. The beneficiaries, in many ways, could benefit from this type of system.

Chairman STARK. Okay, let me just go through this for a minute. The purpose of a DRG thrust, whether you pay it to the hospital or the Doc, is that fair? I mean, technically it may have a different term, but it is the same. You get so much a procedure and you figure out how to save money or the doctor gets the benefit of the productivity increase but we get a chance to set maximum cost to the government, right?

Mr. ANTHONY. There are really two quite different systems with very different implications, if you really take a look at it closely. If you fold it into the DRG system and pay it to the hospital, then it really becomes part of the hospital prospective payment system, so any updates would be those that we presently have in law that deal with the hospital.

You could make it a separate service—I think that is the real distinction—and pay the hospital. It is easier to think about making it a separate type of service with the payment made for the RAP services to physicians.

You could pay a RAP physician group. They then would have the obligation to distribute that money among themselves. But the key point is that the payment in the system is different, so that any kind of an update that you have to that system could be specifically targeted to RAP services, and could take into account things that are peculiar to the physician groups that could be positive or negative. It really has very different connotations.

Chairman STARK. Let me ask you this. I happen to share your opposition to 100-percent mandatory assignment to physicians. I also share your feeling that we ought to encourage participation. But what rationale is there for not, for these particular subspecial-

ties, going to mandatory assignment, perhaps taking away the copay? First of all, the copay is there to limit overutilization. Nobody asks for an anesthetic or a pathological. You do not want to have an autopsy. [Laughter.]

What I am afraid we are doing is, if we are going to go down this road and set a fee for the service, why not, in effect, make it a mandatory assignment, in these instances? It is hard for me to see the opposite side of that and the danger in not doing that is, just as you indicate before. Every time we have contained costs, we have been gamed by volume, right?

Mr. ANTHONY. That is right.

Chairman STARK. What is to prevent us from forcing this same group to maintain their gross income from sticking it to the beneficiaries who have almost no ability, in these subspecialties, to negotiate? On the way to the operating room you do not make those decisions.

Why would it not be both a consumer protection sort of thing? Then the only issue is to pay fairly for the service and why would this be an exception to that opposition to mandatory assignment?

Mr. ANTHONY. You have asked about four questions there. I am going to try to get a few of them and you can come back at me if I do not get all the right answers here.

First of all, I think that you are right and Mr. Gradison is also right in saying that really, when we try to look at the overall physician payment picture, we have primarily come up with proposals that have dealt with price, whether they are freezes or other proposals. We have seen—as a matter of fact, the figures that Mr. Gradison quoted earlier are consistent with the ones I have—that certainly over 40 percent of the increase is a result of volume. We really do need to develop systems that, in fact, deal with that problem.

We feel the RAPS proposal, in fact, is one system that will contain volume. Specifically you are going to put incentives in the system for RAPs, much as in the PPS system, to try to control the use of services ordered and use services and resources more efficiently and effectively.

How does that affect beneficiaries? Are we just going to have a big problem? One reason that we talked about the limits is that you have to realize that those limits are tied to the DRG payment. So to the extent that you find a total excess utilization of services, it is going to come back and have some kind of effect upon the behavior of physicians.

I think it is also important to indicate that we do oppose mandatory assignment. We have a number of reasons for doing that. We are in favor of physicians continuing to maintain their careers; to practice medicine independently. We believe that market forces, to some extent, do result and we think that is important.

We fear that if you have mandatory assignment, that in fact you may end up with situations where you have limited access to care for some beneficiaries and those undoubtedly will end up to be the poor.

I think you are correct in indicating, certainly under the first system that I described—and most people who look at the hospital payment system, or folding into the hospital payment system,

would say—that system makes no sense if you do not have mandatory assignment.

All systems, whether they are the hospital payment option or paying the physician group, have pluses and minuses attached to them. As we have looked at option two, one of the benefits that we see is the fact that it does not require mandatory assignment. That is one reason that we look at it with favor.

Chairman STARK. Would you say that in the absence of market forces, that you ought to look at participation and mandatory assignment? My next question would be describe for me a market force, as between a beneficiary and a RAP? When does the beneficiary get to select on a market basis?

Mr. ANTHONY. The beneficiary, particularly in this instance, does not choose his RAP physician. He chooses an attending physician. Some people have indicated that if the beneficiary does not choose the physician, then why should we worry about not having mandatory assignment and what kind of incentives are there for any kind of efficiencies?

Well, in actual fact, there really is a fairly close relationship between the attending physician and the RAP physicians. In fact, there is a good deal of influence that they can have over what services are ordered, the number, the kinds of tests, et cetera.

Chairman STARK. But that is not my beneficiaries, although the taxpayers may think that those are the beneficiaries of Medicare. The beneficiaries of Medicare are the sick, old people.

Mr. ANTHONY. So what——

Chairman STARK. You are talking about the beneficiary is the RAP or the surgeon or the internist. Let me give you an example. We are encouraging, and we just printed all those books to help our low- and middle-income folks, and say go to a participating physician and all you will pay is your 20 percent.

We have said the same thing under the catastrophic plan, which you and I and Mr. Gradison just put together at great pain and cost and expense and sweat.

Now we blow the whole thing apart. Our lower middle-income person goes to a participating internist and he or she says I am going to have my gall bladder out and I want a participating surgeon and she goes down and the last thing is she ends up with RAPs who do not participate and gets extra billed $5,000 and we have done nothing. And she probably pays it because she is scared not to.

Now, why shouldn't we close in the box and say wait a minute? Why allow this to happen, particularly if that participating physician wants to go to a decent hospital and there is a sole source at the hospital, as often happens?

Mr. GRADISON. Would you yield, Mr. Chairman, on that point?

Chairman STARK. Sure.

Mr. GRADISON. Could that not be resolved if the payment, instead of being made to a newly created RAP group, were made to the admitting physician? The admitting physician then would have an economic stake in trying to find a physician of quality, and the best balance between quality and price among the specialists.

Mr. ANTHONY. You could solve it that way or I think the other answer to the question is that if a patient came in and requested

that the physician use a participating RAPs group, that I would be kind of amazed if the attending physician did not honor that request.

It is also, I think, important to realize that a RAP group would have to decide whether or not they would be participating or not; they pretty much have to do that as a group. You cannot have the radiologists participating and the anesthesiologists not.

Chairman STARK. But you can see that the RAPs may be different in their relationship to patients than most other groups, particularly the primary care and the surgeons, in the market forces that abound?

Mr. ANTHONY. Indeed, they are different and that is one reason that we are proposing the proposal we are.

Chairman STARK. That is why I am suggesting that perhaps you could hew to your conservative, voucher-oriented philosophy and not do a disservice to it by talking about some kind of negotiation which would lead to across the board assignment.

The tradeoff might be no copay, because on the other hand it would be difficult to structure overutilization, particularly in radiology and anesthesiology or where the primary care physician was involved, so that that might be the tradeoff.

Mr. ANTHONY. In actual fact, what you are talking about is pros and cons of various programmatic designs.

Chairman STARK. I guess what I am suggesting is that we have got to keep bringing the beneficiary into this and making sure that not only the Government does not get gypped, but that the beneficiary does not.

Mr. ANTHONY. Let me assure you of two things. One, we are aware of and have thought about all of the issues you just brought up. No. 2, we are not going to propose any system that hurts the beneficiary. As a matter of fact, quality of care and beneficiary protection are at the top of our list and it is those issues, along with the very rapid expansion of costs in this area, that have motivated this proposal.

Chairman STARK. Let the record show that Health and Human Services is humanely concerned.

Mr. ANTHONY. Thank you.

Chairman STARK. And we share that concern.

Mr. GRADISON. Thank you, Mr. Chairman.

In discussing this issue with some of the interested groups, one of the main points they make is that we have basic studies underway with regard to the physician reimbursement issue viewed broadly—the Harvard study—and the work being done by the newly created Physician Payment Review Commission. They ask why we not wait until we get the results of those studies before we react. How would you respond to that?

Mr. ANTHONY. You know, we can always wait and we can study anything to death. But my response is we need to continue to look at physician payment. We need to gather information. We need to do these studies.

But yet, at the same time, I do not think we can sit around continually and not act. So we basically favor moving ahead, doing the best job we can. If we need to alter whatever gets put into place, as a result of those later studies, so be it. But given the very rapid

increase in payments for physicians and the need to come to grips with some of these issues, particularly the utilization question, we just do not think that we should sit around and wait for, at a minimum, 2 years. But by the time Congress considers the issue, you may be talking three or four years before you actually have any kind of major proposals if you wait for the Harvard study findings.

Mr. GRADISON. As I have listened to your explanation of why you have included, in this proposal, radiologists, anesthesiologists and pathologists, I wondered why you stopped there. In particular, why did you not include the emergency room physicians?

Mr. ANTHONY. There are people who have suggested that we do that. I guess that the main reason is that we thought that this was a reasonable set to implement. These were all, as I say, hospital-based services which have had, in the past, special relationships with hospitals, usually contractual.

We thought, also, that that made the most sense and we wanted to primarily deal with the inpatient situation. These physicians, in general, primarily deal with inpatients.

Mr. GRADISON. I understand that, of course, but one could also argue that the emergency room physicians are no more selected by the patient than the RAPs, and maybe even less so. They are really selected by the hospital. They are really serving the hospital, not the admitting physician. In many cases, there is no admitting physician when you are hauled into an emergency room.

Mr. ANTHONY. Clearly, they would be a candidate for eventually including in any type of system. They are fairly consistent with the RAPs scenario.

Mr. GRADISON. My final question has to do with your cost estimates. I am just surprised how rapidly they increase. Is there something going on in these later years that would cause the cost to rise from 10 to 50 and rather rapidly up to 290, all in a 5-year period?

Mr. ANTHONY. Let me tell you how we got them. I think the first number is deceptive because it is implemented at the end of the year. The way the savings estimates are done by the actuaries is to take the base year, and then take the differences. You look at the cost and how fast these services are going up, at 15 percent per year. They are very consistent figures with the ones that you gave.

Then you look at that figure and if you controlled the system and you had the increase be only at something like the MEI, then the difference between those gives you the savings estimates. By controlling utilization of services and hopefully having things more efficiently oriented, the actuaries make those estimates.

But the real reason that the growth is at the rate that you see is because that 15-percent compounded gets up there real quickly. As you indicated, it doubles about every five years and that is what we see here.

Mr. GRADISON. Thank you, Mr. Chairman.

Mr. PICKLE [presiding]. Dr. Anthony, I noticed incidentally that you are a Ph.D.; most of the people coming up here before our committee from HHS are Ph.Ds. Do you all have any honest to goodness, real M.D.s down there with HHS? You do have a few, do you not?

Mr. ANTHONY. Yes, our Administrator is a real M.D. I also have one who came with me today.

Mr. PICKLE. He is a good one, too.

I take it that you recommend bringing the RAPs under the DRG system. I take it you have got one or two options and one is more preferable to the other?

Mr. ANTHONY. Yes, sir.

Mr. PICKLE. Have you taken a position yet or are you just kind of analyzing it and massaging it now?

Mr. ANTHONY. First of all, we definitely are going to propose a RAP DRG system. It is just a matter of which it will be.

Frankly, as I indicated, we have a preference but the information and the data necessary really to distinguish clearly between all the options is just coming in. We got some of the information we got last week; some we have not gotten. So we would like to maintain our flexibility to make the best choices that are possible, as we go through this maze of choices.

Mr. PICKLE. You have, in effect, made up your mind that you are going to go one of the routes of bringing these charges under the DRG system. One is going to be either better or worse than the other and you do not know which one you are going to recommend?

Mr. ANTHONY. Well, there are different combinations and there is the option of asking for the authority as we choose as we go along the way, also.

Mr. PICKLE. You are going to do that, as I gather, by letting HHS set the charges? You take all the average charges of these things and measure them and, unlike the DRG system, now you are going to set the rate? HHS, in effect, would be setting the rate.

Mr. ANTHONY. This would be not too dissimilar from the way the original PPS rates were set, also. What we would do is try to see what, in fact, the average charge for radiology, anesthesiology and pathology services is for each of the procedures that we are talking about. That would set a base average amount.

The update factor, from that, could be negotiated, certainly.

Mr. PICKLE. When you get all that base data, then you, HHS, will set the charge?

Mr. ANTHONY. In a sense, we would not set the charge because that data is going to show averages that are going to be based primarily on the amount that the physicians have traditionally been charging. So whereas we can say that we are going to do the computations and take the data and information that is there, in actual fact the fees or the charges upon which that is based are really going to be ones that the physicians themselves have determined over time.

Mr. PICKLE. If you take data, say for the category of x rays. Let's say the charges in New York are higher than the charges in Rhode Island or neighboring States. What you are saying is there is too much disparity and you are going to get an average rate of all the country and you are going to say that is what it will be? HHS will set the rate on these individual charges?

Mr. ANTHONY. There are some questions as to how you are going to set the rate. Is it going to be one national rate? Are you going to have different rates in different areas? But you are right. Some of the findings that I just saw yesterday, as a matter of fact, indicate

that if you do have a national rate, you are going to have winners and losers. I think Janet Mitchell, who will testify later on today, can and give you some idea as to the amount of changes that would take place if you implement that type of system.

Mr. PICKLE. The point I am trying to make is that obviously you are looking at what you think would be savings over a period of time and whether you would save $600 or $800 million over 5 years. It appears this would save $500 million per year. So savings is a factor as well as uniformity?

Mr. ANTHONY. Yes, sir.

Mr. PICKLE. And you would want to make charges uniform over the country, regardless of regions?

Mr. ANTHONY. We would like to look at the way in which charges are made. I mean, we have never said that we favor a uniform system that does not take into account practice pattern costs, and other aspects. In our general physician payment system, we do not require that there be a uniform charge.

Mr. PICKLE. Mr. Chairman, he is not making me feel any better, so I will yield back the time to you.

Chairman STARK. Do you have any further questions, any feel good questions that you want to leave behind?

Mr. PICKLE. No.

Chairman STARK. Ross, you want to stick around a few minutes? I gather Mr. Levin still wants to inquire and I suspect they will be back in a couple of minutes, if you do not mind.

Do you want to go back and talk some more about the different settings in which these services could be provided?

Mr. ANTHONY. Excuse me?

Chairman STARK. Do you want to talk a little bit more about the settings in which these fees could be provided? Because that is something that kind of——

Mr. ANTHONY. I think you are getting back to your first question?

Chairman STARK. Yes. I do not mean to confuse the issue, but it is the same procedure, and we are encouraging people to go into ambulatory so we got charged less. I gather that it is maybe a third as much for some procedures to be done in an ambulatory care setting.

Mr. ANTHONY. Depending, right.

Chairman STARK. But there is no control or savings to us on the fees that are charged by the physicians who use the ambulatory center. Now, I am just trying to pick ones that are obviously, just on the surface, identical. There may be some that are almost—I mean, it seems to me reasonable to assume that some procedures you would want to be close to an intensive care unit because something might go wrong and a physician might not choose ambulatory.

But on the assumption that some services are performed more than others in these, it just occurs to me it would be a good idea if we are going to go to the trouble and have all the hassle of providing some kind of fee schedule or DRG system or cost containment system, to apply it to the person providing the service, almost regardless of where the service is performed.

If you come at it that way, does that make sense to you?

Mr. ANTHONY. I think I have a little clearer understanding of where you are heading and conceptually I think I would agree with you. I am told that, in actual fact, we really do not have the data necessary to be able to do that easily. But that does not mean you cannot look into it and try to design systems that do it.

I would just add, and we have been working on ASCs and payment rates and things like that. What we have been trying to do in all of those situations is maintain that set of incentives so that the incentives are such to move from the hospital out to the ASC and not, on the other hand, move from the physician's office back to the ASC. So you have got a mix there and certainly I think that is something we should look at carefully.

Chairman STARK. Are you willing to spend a little to save a little? I think you indicated——

Mr. ANTHONY. Should I walk into that trap? [Laughter.]

Chairman STARK. No, but you are only going to save $10 million in 1988, but you are anticipating that you will have almost 30 times that in savings in 1992. Now, I do not know whether you extrapolate that to grow or why such a slow learning curve on the savings?

Mr. ANTHONY. The first year savings are really because the proposal is effective late in the year. It really is not very indicative of what the savings would be. If we look at 1989 it is $50 million and it grows to $290 million in 1992. The primary reason that you get those savings come from the rate of growth at which you have physicians' costs increasing.

Chairman STARK. You are saying that is a strict volume extrapolation?

Mr. ANTHONY. That is the way the actuaries estimate it. They would anticipate that due to efficiencies and due to the fact that, instead of having that 15 percent or greater, it is 15 percent compounded. In 1980 to 1986, it turns out to be 22 percent if you do not have it compounded.

But if you then are updating instead, by the MEI or some other factor, and you are controlling utilization, those things diverge very quickly and that wedges out and you get the kinds of savings that are projected.

Chairman STARK. Let us suppose that one of these groups, or all three of them, came to us and offered mandatory assignment, which is a step toward increasing participation, and the price was doing away with copay or getting a little higher fees or PIP, if you remember that.

Mr. ANTHONY. Only too well.

Chairman STARK. My point is that we are always talking about cutting down and the fact that every time we freeze a fee people go and increase the utilization. I would rather imagine we would have anticipated that. I mean, if the incentive in the world is to make money and you close off one route, and there is only one route left, we might not have thought of it ahead of time, but I am not surprised that that is what they do.

There are other things that are crimes. I mean, calling a procedure something it is not, and I would hope that you would join with me in looking for criminal sanctions rather than just civil

sanctions in those cases in the future. I think that might have a very salutary effect on our cost savings system.

But on the other hand, as Dr. Roper agreed with me the other day, we do not have the most spotless record in the world in dealing with these guys in good faith. I mean, they have some reason to be skeptical of us, as you recall. Maybe you were not here, as I was not, but at some point in the past participating physicians were promised an increase which was later reneged upon.

That does not engender a great deal of confidence in the fact that you and I, even if we put the seal of the United States on the document, are going to keep our word. But let us assume that we get more flies with sugar than vinegar and that maybe we ought to think about dealing. We might have to spend a little in the early years to attract a group, and I am not suggesting conquer and divide, but I am suggesting that if you can start with a group and say look, can we pay you faster so you do not have to hassle with all the paperwork which doctors keep telling me they hate and HCFA hates.

So if we could simplify the payment system or speed it up at a slight increase in cost up front, with the idea that there are long range savings, would HCFA feel like risking a little, too, to see if this might work?

Mr. ANTHONY. Which deal are we working on here?

Chairman STARK. I do not know. Nobody has proposed one, yet, but I am just saying that let us suppose——

Mr. ANTHONY. In general, let me say, I think we ought to be looking at the long run and we have often looked at things——

Chairman STARK. I will give you an example. You do not like mandatory assignment. But let us say we want to increase participation.

Mr. ANTHONY. I had a feeling we would get back to this.

Chairman STARK. What if we say we will raise the fee a little bit if you will participate? Lower the extra billing tremendously but we will come up a little on the Medicare approved fee. That is going to cost us something to begin with. The savings there will benefit mostly the beneficiary, except now with catastrophic care actually we might save some money.

I am just saying is there any reason, as we go along this year, we cannot try to be a little innovative in achieving these goals, because I am sure we are going to hear later today from many people who oppose what the administration is trying to do, and we Democrats are trying to cooperate as best we can.

This is so much fun. [Laughter.]

I guess I only wish you could do this without legislation and then the AMA would really squirm.

Mr. Levin, we have just been having fun waiting for you to get back. That is okay. If you could withhold for just one minute.

Mr. ANTHONY. Let me just say that, as you are well aware, I do not know what deals you have been offered, so it is hard to respond to that.

Chairman STARK. I have been offered more proctoscopic examinations. [Laughter.]

Mr. ANTHONY. That is one that you are going to have to go on your own. [Laughter.]

Chairman STARK. I am just afraid I cannot get a fair one, that is all. [Laughter.]

Mr. ANTHONY. As you know, this would be a legislative proposal and let me say we continue, as always, to want to work with the Congress, and I am sure we will as the time goes forward.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Sorry to break into the enjoyment here.

Just a couple of quick questions. If the savings are so small next year, why not wait until we are sure of where we are going?

Mr. ANTHONY. As you indicate, the savings are quite small next year, but that comes primarily from implementing the program late in the year, and they do grow quite rapidly over the 5 years.

Mr. LEVIN. $50 million you said, right, the following year.

Mr. ANTHONY. Right. The 5-year total is $660 million so it grows quite rapidly. Why wait?

Mr. LEVIN. No, why not wait? If we are not sure——

Mr. ANTHONY. We do not think you really should wait. We think we ought to get going forward. Physician fees are going up really quite rapidly, about 15 percent per year, and it is time to come to grips with this problem and with the problem that utilization is increasing.

We just think it is time to get going.

Mr. LEVIN. Mr. Chairman, you talked about the billings for anesthesiologists and the fact that they presumably already use the relative value system?

Chairman STARK. I do not know as I suggested they use a relative value system.

Mr. LEVIN. No, you have not talked about that. I am told, by them, that they essentially have one that could be put in place.

Chairman STARK. As among themselves, you mean?

Mr. LEVIN. Yes, for their charges. If that is true, let me ask you why not use that for them?

Mr. ANTHONY. We feel really what is important here is to put a system in place much like PPS, that gives incentives to control utilization and provide efficient use of services. A RAPs-type system, parallel to the PPS system, does that. As I understand it and I do not know the details of the anesthesiologists' proposal, what they are really proposing is that you cut down on the price of services via their relative value technique.

As was indicated earlier, you find that over 40 percent of the increase in our payments really results from increased utilization. I do not think that this type of proposal either gets at putting the right kinds of incentives in the system that deal with the utilization problem.

Mr. LEVIN. Are you not spending a good amount of money to study a relative value system for physicians?

Mr. ANTHONY. That is correct. We are.

Chairman STARK. Would the gentleman yield?

Do the anesthesiologists, though, get much into utilization? That seems to me, almost by definition, as out of their bailiwick? I do not know but——

Mr. ANTHONY. Again, this gets back to the question of——

Chairman STARK. I just wanted to deal with——

Mr. ANTHONY. They, of the three groups, probably have the least amount of ability or discretion.

Chairman STARK. So if it is a relative value scale within the types of services that they provide, I mean so much for a tonsillectomy and so much for something else, or so much an hour, does HCFA really care as long as we save some money, I mean, if we are paying an anesthesiologist so much an hour, basically, and they want to weight the procedures by the hour and then if they can do it faster or if it takes longer, they are willing to go with the average, is that a concern?

I think that is what Mr. Levin is getting at, and I will yield back.

Mr. LEVIN. Exactly. I do not understand it from that point of view, but I think the first answer was, in a sense, even more revealing. It is relevant to a system that you are flirting with or at least studying more generally.

Mr. ANTHONY. Let me amplify that a little bit, and bring another aspect into the question. First of all, carriers do use relative value scales presently for anesthesiologists to determine their rates. But in addition to the anesthesiologist, we have a certified nurse anesthetist.

So to the extent that you create a RAP system that allows flexibility in the use of resources, we can find that perhaps certified nurse anesthetists would be substituted for anesthesiologists and we might end up with a more appropriate mix of services.

So, in fact, the incentives that we instill on the system are important here and you cannot, I think, limit yourself to just looking at price if, in fact, you want to reform an overall system.

Mr. LEVIN. You are going to face that with a relative value system in other fields. I will tell you I would raise it and then I will finish so we can go on. There has been a lot of probing questions and I have not been here for all of them.

I do not think you should take that, at least in my part, as hostility towards the objective. I just have kind of an uncomfortable feeling that somebody gave you a budget figure. Having been in the executive for a few years, I know that happened, at least under other administrations, and I think it has been done much more under this one.

They give you a budget figure and you have to find a way to meet it. This subcommittee has to figure out whether you really know what you are proposing. That is the question that I have. Getting these costs under control is necessary but there is an important question, how we do it.

If you are very unsure, the question is with a relatively small beginning savings, whether we should really know what we are doing before we do it.

Mr. ANTHONY. In reference to the relative value scale, and I think—at least if I can infer a little bit—you seem to be indicating that we ought to wait for the results of relative value——

Mr. LEVIN. No, I am saying why not use, we have one supposedly with anesthesiologists. Why not break them out and use it right now for some savings?

Mr. ANTHONY. Certainly, if your only interest in addition to our interest is savings then there are all kinds of ways that you can simply achieve that.

I would like to say that in addition to the savings number, we are interested in a system that gets the right kind of incentives placed into this system. If you look back to the beginning of PPS and all the things that were said about that system, I do not think people would have imagined that the kind of change in practice patterns and the incentives would have had the effect that, in fact, they have turned out to have had.

So we are interested not only in just getting savings. Certainly you and the administration are under tremendous pressure to meet budget guidelines and frankly that is not an insignificant factor, as we are all aware. But we are interested also in trying to put forward policy that has the right kinds of incentives in it.

We feel that this would be more appropriate than simply relying on a relative value scale which, in fact, is not too different from the system that we have right now.

Mr. LEVIN. Thank you, Mr. Chairman.

Chairman STARK. Mr. Moody.

Mr. MOODY. I am sorry, I had to be out of the room for part of your presentation, but let me ask you this. What is the reason why we select these three types of physicians and not the others that also operate in hospitals? I think I heard someone ask about surgical.

Mr. ANTHONY. The reason for these three in particular is that they are in-hospital positions. Primarily patients do not choose these physicians and we see that because their services are provided in a hospital, we can get a handle on those.

In addition to that, it is important to realize that this group of physicians traditionally has had contractual relationships with hospitals and really has operated in a fundamentally different way than lots of other physician groups have.

So it looks like a group that, in fact, we could apply a RAP proposal to and avoid some of the other problems that we might have if we tried to expand that, say to an all physician type of DRG system.

Mr. MOODY. Could not pathologists, for example, easily go out of the hospital to practice off premises and escape from this?

Mr. ANTHONY. It would be pretty hard for a pathologist or even anesthesiologist to move their services. They are usually attached to a surgical procedure so it would be pretty difficult for them to unbundle it or game the system.

I think the example given of radiologists who might be able to take some of those services out more easily is possible. We would continue to monitor to try to be sure that we did not get gamed in those sort of ways. But in actual fact, if you design the price mechanism, it would not be inappropriate to see some of those services move to the outpatient or to some other setting.

Mr. MOODY. But if they moved off premises, would they get out from under the RAP proposal then? For example, radiologists?

Mr. ANTHONY. In actual fact, the way the present proposal is designed, the system is for RAP services for in-hospital procedures.

Mr. MOODY. So would we gain or lose, in terms of quality of medicine, if we begin to see those that could move, move?

Mr. ANTHONY. I really do not think that you would find that physicians would move services out of the hospital in cases where

that might threaten patients in any type of quality of care situation. As a matter of fact, physicians have traditionally been strong advocates for patient care and we have no reason to believe that they would not continue to provide good high quality care. We have every confidence that would be maintained.

Mr. MOODY. On another fact, obviously this seems to require assignment to go along with it, to make it effective. We have not resolved the assignment issue, I guess, and it certainly has its critics. Would this be a nose under the tent of assignment? What does it do to that debate and to that policy consideration, to stick it in right now?

Mr. ANTHONY. There are two basic options, really. One of which, if you fold this into the hospital-based DRG system, is really very difficult to do without having mandatory assignment. If your answer is: if you do that, is this not the nose under the tent? Do you not have mandatory assignment? The answer is clearly yes.

There is another way to do it and that is not to include it in a hospital-based DRG system, but to have it a separate system. You create amounts for payments for RAP procedures but you could pay those—usually, let us say to the physician group, let me call it RAPs, Inc. You pay that group and then they are responsible to distribute it to the physicians.

There are other ways to design it, but under that type of system, mandatory assignment is not required and you can have balance billing. As I indicate, in my testimony, that is the direction that right now we would prefer to go.

Although, let me be clear, we do want to maintain flexibility in case the data and information indicates other alternatives to be more appropriate.

Mr. MOODY. What was the impetus for this proposal? Is it saving money, is it a way of rationalizing resources, or is it just somebody's idea that since hospitals are under DRG, so should these groups?

Mr. ANTHONY. The main reason for the proposal is that we feel that it is important to come to grips with a problem of very rapidly escalating physician costs. One way to do that is a RAPs-type system that puts into place the kinds of incentives that we feel are necessary and appropriate.

So really, the reason for the proposal in the first place has to do with that. We really would like to see good policy aimed at the right kinds of incentives. As you are well aware, very few proposals these days get very far if there are not savings attached to them. Certainly the fact that there were significant savings attached to the proposal was a positive factor.

Mr. MOODY. One of the RAP physicians in my district said they felt it would entail a fundamental shift in authority between the doctors in question and hospital administrators, in favor of the administrators and that it inevitably would impinge on medical decisions. Do you agree with that?

Mr. ANTHONY. Again, that depends upon the system design. If you design the system to pay the hospitals, in fact, that is very true. The anesthesiologists, pathologists, and radiologists would end up negotiating a contract with the hospital and pretty much depending on his ability or whatever factors the hospital thinks im-

portant, that contract, that payment, that relationship would vary and clearly the hospital would have the primary mechanism of control there.

On the other hand, if you have a separate system to pay the physicians, then the physicians are not indebted to the hospital and, as a matter of fact, they have their own separate group. They may have a problem with negotiating and deciding their own contractual——

Mr. MOODY. The RAP, Inc. alternative?

Mr. ANTHONY. Yes, the RAP, Inc. alternative. They would have to come up with agreements among themselves. But in that situation, they are not dependent or at the mercy of the hospital. So it really makes a big difference on how you design the system.

Mr. MOODY. The RAP, Inc. alternative is completely compatible with your proposal? It does not require a change in your proposal, or would that be a modification?

Mr. ANTHONY. No, that is very compatible with our proposal.

Mr. MOODY. Is that the official version now or just——

Mr. ANTHONY. The official version is we are maintaining our flexibility and reviewing pros and cons. As I indicated in my testimony, at this time we prefer option two, or the RAPs, Inc. option. But we are just now getting the data and information necessary to assess all these things.

Some of the data came in last week. We are due to get some more in at the end of this next week. So we would like to maintain the flexibility to design the system in ways that we think are best, both in terms of getting the right kinds of incentives in the system, protecting beneficiaries and having good policies.

So we are trying to keep our options and flexibility open. But as I indicated, there really is a fundamental difference, depending on the options you choose.

Mr. MOODY. And finally, is it possible that you might try out both simultaneously to get comparative data?

Mr. ANTHONY. I doubt that very seriously. I think implementing this proposal is so complex that trying to do it in two different ways would be most difficult.

Mr. MOODY. I mean in different locations. I do not mean simultaneously in the same area.

Mr. ANTHONY. We have no plans to do that at this time.

Mr. MOODY. Thank you, Mr. Chairman.

Chairman STARK. Mr. Daub, do you have any questions?

Mr. DAUB. I do. Am I the last one? Look forward to that, relief is just a Rolaids away.

Mr. ANTHONY. Not necessarily.

Mr. DAUB. Mr. Chairman, thank you very much and I just have one question. That is, a number of organizations contend that the proposal, this RAP-DRG proposal, has the potential of reducing both access to care and quality of care for Medicare beneficiaries and I would like your response to that for the record.

Mr. ANTHONY. We really do not believe that it would reduce either access or quality and frankly, physicians traditionally have been strong advocates for patients, have provided the right kind of appropriate care and we see no reason why they should not continue to do that.

We would design the system and pay an amount sufficient so that physicians, in fact, would continue to provide that kind of good, high quality care. So in actual fact, we do not see that there really would be a problem in this case.

Mr. DAUB. Thank you very much, Mr. Chairman.

Chairman STARK. Thank you very much, Dr. Anthony. We appreciate your candor and your excellent testimony.

Our next witnesses will form a panel. They will be Michael Zimmerman, the Senior Associate Director of the Human Resources Division of the GAO, and Ken Cahill, Specialist in Social Legislation at the Congressional Research Service who is accompanied by Jamie Reuter.

If you would like to proceed to summarize or expand on your prepared testimony in the order that you were called, would you proceed?

STATEMENT OF MICHAEL ZIMMERMAN, SENIOR ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY ROBERT B. SAYERS AND JAMES R. CANTWELL

Mr. ZIMMERMAN. Thank you, Mr. Stark.

Let me begin first by introducing the two people who are with me here today. To my right is Mr. Sayers. He was in charge of the work that we did at the hospitals. And to my left is Mr. Cantwell. He is on my staff in Washington.

I have a statement that will take about 6 minutes to go through, so I hope the Chair will indulge me the extra minute.

Chairman STARK. I certainly will. I have a 1-minute speech and it usually takes me an hour to give it.

Mr. ZIMMERMAN. Thank you, very much.

We are pleased to be here today to discuss the work we are doing for the subcommittee on payments to hospital-based physicians under the Medicare program. Our testimony will address a series of questions we were asked about three hospital-based physician specialties, radiologists, anesthesiologists and pathologists, all three known as RAPs.

The first question dealt with the contractual arrangements between hospitals and RAPs. We reviewed these arrangements in detail in 16 hospitals. Radiologists had written contracts at 13 of the 16 hospitals while anesthesiologists had contracts at only 3. Pathologists either had written contracts or were hospital employees at all 16 hospitals.

We found that five of the written contracts appeared explicitly to grant the contracting physicians exclusive rights to practice their specialty at the hospital. For the remaining 17 written agreements, the contracted physicians were the only ones providing the specialty service at the hospital during 1985, our test year.

As a result, we believe that the written agreements either explicitly stated or appeared, in practice, to result in exclusive arrangements. In addition to the written contracts, verbal agreements also appeared, in practice, to result in an exclusive arrangement. We identified 16 verbal agreements at the hospitals surveyed and 15 of these 16 situations the physicians with agreements were the only

physicians practicing their specialty at the hospital during the test year.

We were also asked whether hospitals have open staffing privileges. That is whether hospitals will accept new applications for staff privileges in RAP specialties. Generally, we found that the 16 hospitals had open staffing policy and that any physician providing RAP services could apply for medical staff privileges on the same basis as any other physician.

As a practical matter, however, the only physicians providing any RAP services on a recurring basis in our sample hospitals, were those who had been affiliated with the contracting physicians.

We were asked whether exclusive contracts or other characteristics of the market for hospital-based physicians result in insufficient restraint on fees. By entering into an exclusive contract with the physicians for the provision of RAP services, a hospital limits the ability of patients and their attending physicians to choose among competing RAPs. Once the hospital is chosen, the patient cannot go elsewhere for necessary RAP services.

But, even if exclusive contracts did not exist, a number of other characteristics of the market for RAP services would tend to limit the ability of competitive market forces to restrain fees. Individual patients and their attending physicians will typically not be very responsive to price differences among competing RAPs for a number of reasons.

For example, RAP service prices are seldom known by the patient before admission to the hospital and the price of RAP services are typically a small part of the cost of a hospital stay.

In contrast hospitals, because of their extensive and recurring dealings with RAPs, should be better situated to arrange for the informed purchase of hospital-based physician services. Hospitals have incentives to control their costs, including amounts paid to RAPs for their supervisory and managerial duties.

The question is whether hospitals have incentives to bargain for part B savings for Medicare and its beneficiaries. Our work suggests that these incentives are, at best, weak.

At the hospitals we reviewed, with two exceptions, we did not see evidence that the hospitals attempted to negotiate fees or other factors influencing patient's part B costs. Though several of the written contracts did include provisions allowing the hospitals to review fees.

Consequently, we cannot conclude that exclusive contracts necessarily result in restrained fees, only that they apparently are not being routinely used by hospitals to create restraint on fees or to require acceptance of assignment.

We were asked a series of questions dealing with the level of RAP physician earnings in comparison with other physician specialties. We found that RAPs were among the specialties with the highest net incomes. According to AMA data, in 1985, 25 percent of all physician's earned incomes of $140,000 or higher. In comparison, during 1985, 25 percent of the radiologists net income were $200,000 or higher. The comparable figures were $169,300 for anesthesiologists and $155,000 for pathologists.

Medicare requires its carriers to employ utilization review activities to prevent, identify and recover payments for physician serv-

ices that are not medically necessary. We found that HCFA had no specific requirements for inpatient RAP services. Three of the four carriers serving the four geographic areas in our sample, however, had developed limited pre-payment screens for selected RAP services and performed special postpayment studies of RAP claims during the period 1983 to 1985.

The last question we are going to address was how Medicare reimbursement of hospital-based physicians varies across geographic areas. We found considerable variation in Medicare payments across the four geographic areas we looked at.

For example, different carriers used different complexity values in computing allowed anesthesiology charges for the same procedures. This contributed to the geographic difference in payments. Because the procedure's complexity should not vary across geographic areas, we believe that such differences for the same procedures may not be warranted.

For 6 of the 13 anesthesiology procedures we reviewed, the differences in complexity values added from 20 to 70 percent to the allowed amounts, all other factors being equal.

The relative differences between the allowed amounts for the pathology and radiology procedures we examined were similar to differences determined for the anesthesiology procedures. In summary, these wide variations in allowed amounts raised concerns in terms of both equity and reasonableness of program payments. We will be examining this issue further in future work.

That concludes my prepared remarks, Mr. Chairman.

[The prepared statement follows:]

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Statement of
Michael Zimmerman, Senior
Associate Director
Human Resources Division

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the work we are doing for the Subcommittee on payments to hospital-based physicians under the Medicare program. Our testimony will focus on addressing a series of questions we were asked about three hospital-based physician specialties--radiologists, anesthesiologists, and pathologists (RAPs). These questions dealt with: (1) the contractual arrangements between hospitals and RAPs and the market structure for services provided by these physicians; (2) the level of RAP physician net income, and percentage return to medical training; (3) Medicare's controls on the volume of these physicians' services; and (4) the geographic variation in payment rates for their services.

You expressed concern that the widespread use of exclusive service contracts between hospitals and RAPs may lead to excessive fee levels and that the financial interests of the Medicare program and its beneficiaries may not be adequately represented when hospitals and physicians negotiate these exclusive arrangements.

In summary, we found that exclusive contractual arrangements between RAPs and hospitals are quite common in practice. Although these contractual arrangements can facilitate the efficient delivery of hospital services, the ones we reviewed were generally not being used by hospitals to restrain Medicare fees or limit beneficiary out-of-pocket costs. We believe that hospitals have little incentive to bargain with hospital-based physicians to restrain the physicians' charges to Medicare beneficiaries.

BACKGROUND

RAPs provide services essential to the operation of hospitals and necessary for the diagnosis and treatment of illness and injury. They are the experts in performing and interpreting the laboratory tests and X-rays other physicians need to decide how to appropriately treat patients and in administering the anesthetics necessary to perform many of those treatments. In 1985, these three hospital-based specialties accounted for 11.4 percent of the total U.S. supply of physicians and about 13.6 percent of the Medicare part B physician outlays. Radiologists, the specialty within the group with the highest level of Medicare payments, accounted for 4.5 percent of the physician supply and about 8 percent of the Medicare physician outlays.

Medicare part B payments for RAP services are generally 80 percent of the "reasonable" or "approved" charge for covered services, after the beneficiary has met the part B annual deductible of $75. The Medicare beneficiary is then responsible for paying the remaining 20 percent of the approved charge. In addition, the beneficiary is responsible for paying the difference between the amount the physician charges for the service and the approved charge, unless the physician accepts assignment. "Accepting assignment" means that the physician agrees to accept the approved charge as payment in full. Physicians have the option of becoming a Medicare participating physician, in which case they agree to accept assignment on all Medicare claims. Beginning in 1987, physicians who do not participate are subject to limitations on the maximum amount, called a maximum allowable actual charge, they can charge Medicare patients. Because of concerns the Congress has had about payment for the services of hospital-based physicians, several payment provisions apply uniquely to these physicians.

PREVALENCE OF EXCLUSIVE CONTRACTS

We were asked to review the contractual arrangements in selected geographic areas between hospitals and hospital-based physicians to assess whether the contracts granted the physicians exclusive practice rights at the hospitals or allowed for competition among physicians. With very few exceptions, at the 16 hospitals we visited, both written and verbal contractual arrangements appeared to be exclusive, either explicitly or because the contracted physicians were the only practicing physicians providing their specialty services on a recurring basis at these hospitals.

We reviewed the contractual arrangements between RAPs and hospitals in detail at four hospitals in each of the geographical areas reviewed--Maine; Rhode Island; Dade County, Florida; and Queens County, New York. At 13 of the 16 hospitals, radiologists had written contracts, while anesthesiologists had written contracts at only three hospitals. Pathologists either had written contracts or were hospital employees at all 16 hospitals.

Arrangements between physicians providing RAP services and hospitals were not standardized at the hospitals we reviewed. The written contracts included a variety of provisions, such as:

-- requiring the hospital to provide the contracting physicians the necessary equipment, supplies, and non-physician personnel;

-- giving the contracting physicians authority to operate the department, including supervising hospital employees;

-- giving exclusive use of the hospital department facilities and equipment to the contracting physicians; and

-- requiring the contracting physicians to provide enough physicians to meet the department's staffing requirements.

In an article[1] discussing a 1984 American Hospital Association survey of hospital-medical staff relationships, an exclusive contract was defined as

> ". . . a written agreement that gives a physician or physician group the right to provide administrative and clinical services in the operation of a hospital department; the agreement precludes other physicians from practicing that specialty in the hospital for the period of the contract."

The AHA survey found that about 62 percent of the pathology, 60 percent of the radiology, and 30 percent of the anesthesiology departments in the 3,601 hospitals responding had exclusive contracts in those departments.

Using the above definition of exclusive contracts, we found that nearly one-fourth of the written agreements reviewed (5 of 22) at the 16 hospitals appeared to grant the contracting physicians exclusive rights to practice their specialty at the hospital. For 15 of the 17 other written agreements, the contracted physicians were the only practicing physicians providing their specialty services at these hospitals during 1985. As a result, we believe that 20 of the 22 written agreements either explicitly stated or appeared in practice to

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[1]Morrisey, M. and D. Brooks, "The Myth of the Closed Medical Staff," Hospitals, Vol. 59, No. 13 (July 1, 1985), pp. 75-77.

result in exclusive arrangements. (The two exceptions were (1) a written agreement with a pathology group at one hospital that gave the hospital the right to select a chief pathologist from outside the pathology group and (2) a contract with a radiology group that allowed the hospital to employ radiologists outside the group. Officials at both hospitals told us that neither contract provision has been exercised.)

In addition to the written agreements, verbal agreements also appeared in practice to result in exclusive practice arrangements at most of the hospitals we reviewed with such agreements. We identified 16 verbal agreements at the hospitals surveyed. In 15 of these 16 situations, the physicians with agreements were the only physicians practicing their specialty at the hospital during 1985. In the remaining situation, an anesthesiologist outside of the contract group occasionally practiced at the hospital.

However, we noted at one of the hospitals a situation involving a verbal agreement had changed significantly since 1985. At this hospital the group of physicians who had provided anesthesia services for a number of years under a verbal agreement believed that they had an exclusive agreement. The hospital decided to hire additional anesthesiologists and was doing so at the time of our visit. The anesthesiology group contended the hospital could not hire anesthesiologists from outside their group without their consent and was litigating the matter.

HOSPITAL RAP STAFFING

We were also asked whether hospitals have open or closed staffing privileges--that is, whether the hospitals will accept new applications for staff privileges in RAP specialties. We found that hospitals' staffing arrangements for RAPs officially were open but in practice only RAPs with contracts provided services.

According to the 1984 article discussed above, a closed medical staff is defined as one where ". . . a hospital does not accept new applications for any category of medical staff privileges--either temporarily or for an indefinite period of time." Using this definition, we generally found that the 16 hospitals visited had an open staffing policy in that any physician providing RAP services could apply for medical staff privileges on the same basis as any other physician. The five hospitals, which had granted exclusive practice rights to selected RAP physicians, were the only exceptions to this open staffing policy. As a practical matter, however, the only physicians providing any RAP services on a recurring basis in our sampled hospitals during 1985 were those who had been affiliated with the contracting physicians' groups. The only exception to this was at one hospital where an anesthesiologist outside the physician group having the agreement provided some services.

EFFECTS OF EXCLUSIVE CONTRACTS AND OTHER MARKET CHARACTERISTICS ON RAP FEES

We were asked whether exclusive contracts or other characteristics of the market for hospital-based physicians result in insufficient restraint on fees. The market for RAP services has several characteristics that tend to limit the ability of market forces to restrain fees, even without exclusive contracts. In the case of exclusive contracts, although hospitals negotiate the contract provisions, they do not bear the costs of nonsalaried RAP physicians' part B services. Those costs are paid for by Medicare and its beneficiaries. Also, neither patients nor their admitting physicians typically choose hospitals based on the price of RAP services. As a result, the hospital has little incentive to negotiate low rates for the

physicians' direct patient care services or the acceptance of assignment by these physicians. And few of the contracts we reviewed explicitly provided for restraint on fees or acceptance of assignment. There are, however, a number of ways that exclusive contracts can facilitate the efficient delivery of hospital services.

By entering into an exclusive contract with physicians for the provision of RAP services, a hospital limits the ability of patients and their attending physicians to choose among competing RAPs. Once the hospital is chosen, the RAPs who will provide ancillary services are determined--i.e., the patient cannot go somewhere else for the necessary RAP services.

But, even if exclusive contracts did not exist, a number of other characteristics of the market for RAP services would tend to limit the ability of market forces to restrain fees. Individual patients and their attending physicians will typically not be very responsive to price differences among competing RAPs for a number of reasons, including:

-- the fees and the ancillary services that will be required during the hospital stay are rarely known by the patient in advance, partly because there is little repeat business;

-- the services are ancillary to the reason for admission;

-- hospital selection is typically not made on the basis of the price of RAP services; and

-- the price of the hospital-based physicians' services are typically a small fraction of the total cost of the hospital stay. (For some Medicare beneficiaries, however, the cost of hospital-based physicians' services could be a large part of their out-of-pocket cost for the hospital stay.)

In contrast, hospitals, because of their extensive and recurring dealings with RAPs, should be better situated to arrange for the informed purchase of hospital-based physician services. Hospitals have incentives to control their costs, including amounts paid to RAPs for their supervisory and managerial duties. The question is whether hospitals have incentives to bargain for part B savings for Medicare and its beneficiaries. Our work suggests that these incentives are at best weak. At the hospitals we reviewed, with two exceptions, we did not see evidence that the hospitals attempted to negotiate fees or other factors influencing patients' part B costs--though several of the written contracts did include provisions allowing the hospitals to review fees. The two exceptions involved (1) a hospital which required radiologists to accept assignment, and (2) a hospital which required radiologists to limit fees to 6 percent above prevailing charge levels.

Our review of health economics literature identified two papers that maintained that competition among hospitals for patients can encourage hospitals to negotiate fee restraints with their hospital-based physicians.[2] In essence, these papers presented the argument that hospitals would want to keep RAP fees reasonable in an effort to compete for patients. But the

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[2]Lynk, W., "Restraint of Trade through Hospital Exclusive Contracts: An Economic Appraisal of the Legal Theory," Journal of Health, Politics, Policy and Law, Vol. 9, No. 2 (Summer 1984), pp. 269-279 and Lynk, W. and M. Morrisey. "The Economic Basis of Hyde: Are Market Power and Hospital Exclusive Contracts Related?" Mimeographed (July 1986).

effectiveness of competition among hospitals for patients as it pertains to exclusive contract provisions is limited by a number of factors. As mentioned above, RAP service prices are seldom known by the patient before admission to the hospital. Further, the choice of a hospital is usually made because of the admitting physician's recommendations, the hospital's reputation in the community, previous use, location, and medical staff reputation.

There are a number of ways, however, in which use of exclusive contracts can, in certain circumstances, facilitate efficient delivery of hospital services. For example, among other things, it can

-- increase the hospital's control over operation of the department;

-- lower costs through standardization of administrative procedures and centralized administration of the department;

-- permit better scheduling of the use of facilities;

-- improve the quality of services by assuring that physicians perform enough procedures to maintain their proficiency, have an incentive to upgrade their skills, and are subject to hospital standards of quality.

To the extent that these factors increase efficiency, reduced hospital costs may result.

Further, we note that in Jefferson Parish Hospital District No. 2 v. Hyde (1984), the Supreme Court reviewed for the first time issues involving hospital-physician contracts, unanimously holding that an exclusive contract between a New Orleans area hospital and a group of anesthesiologists did not violate federal antitrust law. The court held that the arrangement was not per se illegal and did not unreasonably restrain competition in actual operation.

In summary, we cannot conclude that exclusive contracts necessarily result in unrestrained fees, only that they apparently are not being routinely used by hospitals to create restraints on fees or to require acceptance of assignment. We believe that hospitals have few incentives to use exclusive contracts to bargain with hospital-based physicians to restrain physician charges to Medicare beneficiaries.

RAP EARNINGS AND RATES OF RETURN

We were asked a series of questions dealing with the level of RAP physician earnings in comparison with other physician specialties. We found that the RAPs were among the specialties with the highest net incomes. Further, when physicians net incomes were standardized for the cost of medical education, including the length of medical specialty training, and expressed as a return on specialty training, anesthesiologists, radiologists, surgeons, and pathologists--in that order--had the highest financial return on their training.

RAPs Net Incomes are Among the Highest

RAPs earn higher net incomes than most other physicians, according to AMA data. The 1985 mean pretax net income for all physicians was $113,200. The 1985 mean pretax net income was $150,800 for radiologists, $140,200 for anesthesiologists, and $127,000 for pathologists. Compared with 1981 net income figures, the 1985 net incomes represent a 28.9 percent increase from $116,900 for radiologists, an 18.2 percent increase from $118,600 for anesthesiologists, and a 21.7 percent increase from

$93,000 for all physicians. These percentage increases are greater than the percentage increase in the Consumer Price Index (CPI), which increased 17.6 percent between July 1981 and July 1985. Missing data preclude us from making a similar comparison for pathologists.

Another way of looking at RAP incomes is that, in 1985, 25 percent of all physicians earned net incomes of $140,000 or higher and 50 percent earned net incomes of $95,000 or higher. In comparison, during 1985:

-- 25 percent of the radiologists earned net incomes of $200,000 or higher, and 50 percent earned incomes of $150,000 or higher;

-- 25 percent of the anesthesiologists earned net incomes of $169,300 or higher, and 50 percent earned incomes of $128,000 or higher; and

-- 25 percent of the pathologists earned incomes of $155,000 or higher, and 50 percent earned $120,000 or higher.

Data from the Health Care Financing Administration (HCFA) on physician income in 1983 by type of employment also show evidence of high net incomes for hospital-based physicians. The four employment categories are hospital employee, clinic or health maintenance organization employee, corporate or other physician employee, and self-employed. Self-employed radiologists ($130,400), anesthesiologists ($134,100) and pathologists ($124,000) earned incomes higher than for all self-employed physicians ($99,600), with net incomes higher than all other specialties except cardiovascular disease ($130,000) and orthopedic surgery ($140,500). In the settings where the physicians were employees, for RAPs as well as for most other physician specialties, incomes were generally lower.

Rates of Return on Medical Training Are High for RAPs

In 1983, RAPs earned higher rates of return to medical education than physicians overall, according to a study funded by HCFA. Rate of return calculations are a way of comparing physicians' net earnings from medical practice, which consider the cost and length of medical training. Radiologists, anesthesiologists, and pathologists earned annual rates of return of 20, 22, and 17 percent, respectively, compared with 16 percent for all physicians. The return for surgery was 19 percent; the other specialties earned rates of return that were lower than any of the RAP specialties.

UTILIZATION REVIEW IS LIMITED

We were asked whether existing payment mechanisms provide for control on volume growth and whether these controls are effective.

To control the number of services being provided and prevent unwarranted growth, Medicare employs utilization review to prevent, identify, and recover payments for physician services that are not medically necessary. Medicare carriers, which are insurance companies used by HCFA to process physician Medicare bills, may perform these reviews on either a prepayment or postpayment basis. HCFA has no special requirements beyond those normal for all physician services for prepayment review of RAP claims. HCFA has required reviews of office radiology services on a postpayment basis.

Three of the four carriers serving the four geographic areas in our sample have developed their own prepayment screens for RAPs, and three of them performed special postpayment studies of

RAP claims during the period 1983 to 1985. For example, Blue Shield of Florida developed a prepayment screen to identify multiple anesthesia procedures for the same beneficiary on the same day. This screen reportedly enabled the carrier to save $249,241 during calendar year 1985. Florida Blue Shield also conducted a special postpayment review in 1985 of 10 Florida pathologists to determine whether pathologists were billing for clinical pathology procedures normally performed by laboratory technicians. Based on the results of this study, Florida Blue Shield is attempting to recover a total of about $59,000 from the 10 pathologists, and has established a prepayment screen to identify, for further review, claims involving more than one clinical pathology consultation per beneficiary per day.

The program savings generated by these carriers' prepayment utilization review edits are generally much more than the related costs. Carrier officials believed, however, that the potential for identifying additional questionable claims for RAP services through utilization review is limited. This is because RAP services normally are ordered by a physician other than the one providing the service, and the RAP physician is therefore generally not in a position to increase service volume.

In addition to the above utilization controls under part B, since the implementation of Medicare's hospital prospective payment system, hospitals have a strong incentive to limit ancillary services to the extent that they increase part A costs--such as the cost of administering and managing the RAP departments. This is because, under PPS, hospitals are paid a predetermined amount based on the patient's diagnosis. If services are provided for less than this amount, the hospital makes a profit. If the costs exceeded the payment, the hospital suffers a loss. Thus, PPS could be expected to exert some limiting effects on the volume of RAP services.

PAYMENT VARIES ACROSS GEOGRAPHIC AREAS

The last question we were asked to address was how Medicare reimbursement of hospital-based physicians varies across geographic areas. We found considerable variation in Medicare payments across the four geographic areas we looked at.

To answer this question, we analyzed a group of high-cost procedures, including 13 anesthesiology, 4 pathology, and 5 radiology procedures. We selected these 22 procedures because, in Rhode Island Medicare part B payment records, they accounted for at least 25 percent of the allowed charges for each type of physician.

In the four locations reviewed, the allowed charges for radiology services provided at a hospital were much lower than for the other two specialties. About 50 percent of the allowed radiology charges were for services provided at a hospital; the percentages for anesthesiology and pathology were about 96 and 70 percent, respectively. Allowed charges for radiology and anesthesiology procedures were generally higher in Florida and Queens, New York, than in Maine and Rhode Island. For pathology, allowed charges were highest in Maine and Florida.

The four carriers determined allowed charges for anesthesiology services using the same methodology. First the number of service units allowed for a given procedure was determined. (The number of service units is the sum of base units, a measure of complexity and risk, and time units, a measure of how long the procedure took.) The number of service units is then multiplied by a dollar conversion factor, which is based on physicians' past charge patterns. The product is the allowed charge for the procedure.

These allowed amounts for anesthesia varied significantly. For instance, the allowed amount for anesthesia provided during a cataract extraction with lens implantation--a common procedure for Medicare beneficiaries--varied from $285 in Queens County, New York, to $152 in Rhode Island--an 88-percent difference for the same procedure. Other common anesthesiology procedures showed considerable variation in allowed amounts, with 8 of the 13 anesthesia procedures we reviewed showing differences in the amount allowed at least as large as those for cataract extraction.

We found that different carriers use different base units in computing allowed anesthesiology charges and that this contributes to the geographic difference in payments. Because base units represent the complexity and risk of a given procedure, we believe that base unit differences for the same procedures may not be warranted.

We found significant base unit differences for 6 of the 13 procedures analyzed in the four locations reviewed. The base unit differences varied from 20 to 70 percent for the six procedures. For example, the base units for anesthesia for a "total hip replacement, simple," ranged from 7 in Florida and Rhode Island to 12 in New York. The effect of this would be to introduce a 70 percent-difference in allowed amounts across these geographic areas, all other factors being equal.

Allowed charges for pathology services were generally lower in Rhode Island and Queens, New York, where most of the pathologists were paid by the hospital for patient care.

The differences between the allowed amounts for the four pathology procedures we examined were similar to differences determined for the anesthesiology procedures. For example, in Maine and Florida, the average allowed amount was $73 and $69, respectively, for a certain tissue analysis pathology procedure related to patients having undergone surgery, while in Rhode Island or Queens, New York, the average allowed was slightly over $46 for the same procedure.

Similarly, we found significant differences in Medicare allowed amounts for the same radiology procedures among the four carriers. For example, a radiologist in Rhode Island would receive about $31 for a two-view chest X-ray done in a physician's office, while a Queens, New York, radiologist would receive almost $44--a 42-percent difference.

In summary, these wide variations in allowed amounts raise concerns in terms of both equity and reasonableness of program payments. We will be examining this issue further in future work.

This concludes my remarks. I will be happy to answer any questions you may have.

Chairman STARK. Thank you. Mr. Cahill.

STATEMENT OF KEN CAHILL, SPECIALIST IN SOCIAL LEGISLATION, EDUCATION AND PUBLIC WELFARE DIVISION, CONGRESSIONAL RESEARCH SERVICE, LIBRARY OF CONGRESS, ACCOMPANIED BY JAMIE REUTER, SPECIALIST IN SOCIAL LEGISLATION

Mr. CAHILL. Thank you, Mr. Chairman.

In addition to Dr. Reuter, I would like to introduce the other members of the CRS team working on our report, Gene Falk, Janet Kline, and Jennifer O'Sullivan.

Mr. Chairman, at your request and that of the ranking minority member, CRS has prepared a report on issues related to changing the way in which Medicare pays for services provided by hospital-based physicians.

Specifically, the committee requested that CRS examine issues related to paying for radiology, anesthesiology, and pathology services under a prospective payment system similar to that which Medicare uses to pay hospitals.

In recent years, the Congress has placed a number of limits on physician payments under Medicare. The basic fee for service payment method has, however, remained relatively unchanged since the beginning of Medicare. It has been suggested that the current system has led to imbalances in payments for individual services and contributes to increasing expenditures.

It also has been suggested that the system fails to provide adequate protection for the elderly against rising physician fees.

While, as would be expected, there is disagreement on problems with the current system and the need for reform, congressional interest continues. At hearings held by this committee last June, a number of witnesses suggested that a start on physician payment reform could be made by focusing on RAP services and paying for them under a prospective payment system.

Chairman STARK. Excuse me, Ken. Do you want to suspend for a minute. I would like to hear this and follow along as you summarize it. I think we will just recess for 5 minutes and we will run and vote and come right back. Will you excuse us.

Mr. CAHILL. That is fine, Mr. Chairman.

[Recess.]

Chairman STARK. Thank you, Mr. Cahill.

Would you like to pick up where we interrupted you?

Mr. CAHILL. Thank you, Mr. Chairman.

Several reasons have been cited for focusing on RAP services. Hospital based physicians who provide the majority of in-patient RAP services traditionally have had special relationships with hospitals, such as contracts to provide both administrative and professional services in hospital radiology, anesthesiology, and pathology departments.

Second, while competitive forces may work in the provision of some physician services through the ability of patients to select their physicians, they may work less well for RAP specialists who are not normally chosen by the patient.

The reasons for singling out RAPs have been countered by some. Having financial and other contractual relationships with hospitals is not restricted to RAP physicians. Other specialists, such as emergency room physicians, may also have financial arrangements.

Also, while radiologists, anesthesiologists and pathologists may provide the majority of in-patient RAP services, many other type of physicians provide these services as well.

Using 1984 data from the Health Care Financing Administration, the CRS report presents information on RAP services and charges. Inpatient RAP services accounted for less than half of all RAP charges and less then 10 percent of Medicare's part B benefit payments; 94 percent of anesthesiology, 40 percent of radiology, but just 14 percent of pathology charges were for in-patient services. It should be remember, however, that a significant portion of what are commonly considered RAP services—for example, much of clinical pathology—is paid for under part A rather than part B of Medicare.

We found a reasonable association between the DRG classification system and RAP inpatient charges. Our analysis made clear, however, that the degree to which the DRG classification was related to current charges was very sensitive to expensive, or outlier, cases. Also, even if physician pricing differences, geographical location and teaching activity are taken into account, over half of the variation in RAP charges is left unexplained by the DRG classification, if no provision is made for outlier cases.

Congress may attempt to achieve a number of goals through a RAP-DRG payment system. The goals for a RAP-DRG system may include, but are not limited to controlling or reducing Medicare expenditures; controlling or reducing beneficiary liability; encouraging appropriate patterns and quality of care; and promoting or maintaining access to care.

A RAP-DRG payment system would create incentives to reduce the total cost of services provided on an in-patient basis by shifting some of the financial risks from the Medicare program to the entity receiving fixed payment for in-patient services.

Responses to the new incentives could take several forms. The medical system could respond by reducing the volume of services provided during an in-patient episode, seeking lower cost substitutes by, for example, using a less expensive mix of services or finding a substitute for relatively expensive physician specialists; reducing the price per unit of service; increasing the efficiency of services; that is reduce the non-professional costs and the physician time per unit of service; or by avoiding potentially expensive or high risk cases.

Whether or not the RAP-DRG system achieves the overall objective for the physician payment reform depends, in part, on which of these responses occur. However, the probability of each response is dependent on who is given the RAP-DRG payment and the ability of the entity to bring about a particular response.

As indicated by my preceding remarks, the success of a RAP-DRG payment system in meeting goals set by the Congress depends on a number of specific design features. The CRS report identifies a number of these design features and discusses the issues involved.

Among the prominent design issues are the definition of the services to include in the DRG payment, the need for adjustments to the basic payment rates to reflect accepted differences in pricing or patterns of care; the need for an outlier policy to limit the financial risks of expensive cases; and resolution of questions concerning beneficiary cost sharing.

Mr. Chairman, each of these issues will affect the ability of a RAP-DRG system to meet congressional goals. Our report and the statement submitted for the record address these issues in more detail.

This concludes my statement and I thank you for the opportunity to conduct the study. We would be happy to answer any questions.

[The prepared statement follows:]

A PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL-BASED PHYSICIAN SERVICES UNDER MEDICARE: A SUMMARY OF ISSUES AND DATA

At the request of the Committee on Ways and Means Subcommittee on Health, the Congressional Research Service (CRS) has prepared a report on issues related to one method of changing the way Medicare pays for certain hospital-based physicians' services. Specifically, the Committee requested that CRS examine issues related to paying for radiology, anesthesiology, and pathology (RAP) services under a prospective payment system similar to that used by Medicare to pay for most hospital services. This statement summarizes the issues and findings of our report.

The debate on reform of physician payment under Medicare has highlighted three major reform options--revising the current fee-for-service payment system to incorporate a scale of relative values for individual procedures; paying for "bundles" of physician services based on a prospectively determined payment rate; and paying a set fee per beneficiary to an organization for all services for a given period of time (so-called capitation payments). Congress has asked other organizations, notably the Physician Payment Review Commission and the Department of Health and Human Services (DHHS), to report on various aspects of these reform options. The CRS study focuses specifically on a subset of the prospective payment system reform option dealing with RAP services.

The CRS study reviews and analyzes the many design issues associated with developing a prospective payment system for RAP services. It does not examine any particular proposal, nor does it estimate the specific financial risks associated with a particular policy option.

A. Background

While the Congress has, in recent years, placed a number of limits on physician payments, the basic fee-for-service payment methodology has remained relatively unchanged since the program's inception. It has been suggested that the current payment system led to imbalances in payments for individual services and that the use of the individual service as the payment unit is inflationary. It also has been suggested that the system fails to provide adequate protection for the elderly against rising physicians' fees.

While research continues on the development of alternative payment systems for all physician services, some have expressed interest in a more narrowly defined classification of services, for example RAP services provided to hospital inpatients. While there has been no readily available empirical evidence either to support or refute the viability of a RAP/DRG payment option, several reasons have been offered for further examining this approach.

First, radiologists, anesthesiologists and pathologists who provide the majority of RAP services to hospital inpatients traditionally have had a special relationship with hospitals. Radiologists, pathologists, and to a lesser extent anesthesiologists, have contracted with hospitals to provide both administrative and professional services in hospital radiology, laboratory and anesthesiology departments. Historically, especially prior to Medicare, radiologists and pathologists, but not anesthesiologists also billed for their services through the hospital.

Another major reason which has been cited for possibly segregating RAP payments relates to how services are generally ordered and delivered in the hospital setting. Some have suggested that while competitive forces may operate in the fee-for-service marketplace for physicians as a group, such forces may not operate, or operate differently, with respect to RAP physicians. Patients are often directly involved in the selection of physicians who provide their primary and surgical care. Theoretically, patients may base their selection of these physicians on comparisons of such factors as perceived quality of care, convenience and price. However, they are rarely involved in the selection of physicians providing RAP services. The attending physician sometimes may select these physicians from among the RAP specialists on the hospital's staff. The selection of a RAP physician may also be determined by hospitals' policies and staffing patterns. Through his ordering practices, the attending physician also defines the type and amount of RAP services to be provided. However, neither the attending physician nor the hospital have any

incentive for factoring economic considerations into the choice of RAP specialist.

A number of concerns have been raised with respect to the potential implementation of a DRG-type payment scheme for all inpatient services. These include how well the DRG classification system reflects physicians input costs, deciding who should receive the DRG payment, and determining beneficiary liability. It has been suggested that some of these concerns might be more easily addressed in the context of a bundling approach limited to RAP services.

While a number of reasons have been offered for possibly segregating payments for RAP services there are also a number of arguments which could be offered against such an approach. Financial relationships between hospitals and physicians are not limited to the three RAP specialist groups; other physicians, for example emergency room physicians, may also have financial arrangements with hospitals. Further, radiologists as well as anesthesiologists are now primarily operating on a fee-for-service rather than under a salary or percentage arrangement with hospitals. Since it is generally the attending physician rather than the RAP physician who exercises the major control over the type or volume of services provided, it may not be appropriate to single out RAP physicians in an attempt to control the volume of physician services. Finally, the theoretical assumption that competitive forces operate in the fee-for-service marketplace for physicians as a group but not for RAP physicians. However, there is no general agreement that competitive forces actually operate with respect to pricing and production decisions of physicians as a group.

1. Payments for RAP Services

Radiologists, pathologists, and to a lesser extent anesthesiologists frequently have some form of financial arrangement with the primary hospital with which they are affiliated. However, these arrangements may not be in the form of a written financial contract. The arrangements between hospitals and RAP physicians specify compensation methods for services provided by these specialists. There are three primary ways that radiologists, anesthesiologists, and pathologists have been compensated. These are fee-for-service, salary, and percentage arrangements (either a specified percentage of gross department billings or net department billings). Fee-for-service has traditionally been the principle compensation method for anesthesiologists. Prior to the implementation of Medicare in 1966, the majority of services provided by radiologists, and pathologists were billed by or through the hospital. In 1965, roughly two-thirds to three-quarters of radiologists were compensated under a percentage arrangement. By 1983, 80 percent of radiologists relied on fee-for-service as their primary method of compensation. In 1965, roughly one-half of pathologists were compensated on a percentage basis and roughly one-quarter were compensated on a salary basis. By 1983, almost no pathologists reported a percentage arrangement with the primary hospital with which they were affiliated. Approximately one-half reported a salary or similar arrangement with the primary hospital with which they were affiliated and over one-quarter reported that their arrangement was fee-for-service billing.

These changes in compensation arrangements over time reflect the implementation of Medicare and subsequent legislative and regulatory changes made in the program's payment rules. Medicare excluded the services of hospital-based physicians from payment under the Hospital Insurance (HI) or part A program and provided instead that payment for all physicians' services would be made under part B. Physicians were therefore required to separate that portion of their services which constituted direct patient care services, the so-called professional component paid for under part B, from those services provided to the institution, the so-called provider component paid for under part A. However, a billing option was devised which allowed hospitals to submit bills for hospital-based specialists without an item-by-item separation of these two components. The split between the two components was to approximate that which would occur if the bills were itemized. This billing method became known as combined billing.

The Social Security Amendments of 1967 authorized 100 percent (rather than 80 percent) reasonable charge payments for inpatient radiology and pathology

services. The intent of the provision was to simplify billing practices by avoiding the necessity of making a distinction between the professional and technical components on a patient-by-patient basis. The provision was modified effective July 1, 1981, by limiting its application to situations where the physician agreed to accept assignment. The 100 percent reimbursement provision was eliminated entirely effective October 1, 1982.

Major changes in reimbursement for hospital-based physicians were incorporated in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). As noted, existing law and regulations specified that direct patient care services were to be reimbursed under Medicare part B while services performed for the institution by provider-based specialists were to be reimbursed as provider services on the basis of reasonable costs under Medicare part A. However, there was concern that this policy had never been uniformly implemented. TEFRA directed the Secretary to issue regulations which distinguish between: 1) professional medical services which are rendered to an individual patient, which contribute to the patient's diagnosis and are reimburseable only on a charge basis; and 2) professional services which are of benefit to patient's generally and which can be reimbursed through hospitals' part A payment. Implementing regulations (generally referred to as TEFRA regulations) and accompanying instructions specify a series of general criteria which must be met in order for the service to be considered a part B service. Further, individual criteria are detailed for anesthesiology, radiology, and pathology services respectively. Regulations also eliminated combined billing arrangements effective October 1, 1983. This was also the implementation date of the TEFRA requirements and the beginning date of the new prospective payment system (PPS) for hospitals.

Since October 1, 1983, RAP services which do not meet the criteria to be reimbursed on a reasonable charge basis under part B are reimbursed under the PPS or, in the case of PPS-exempt hospitals, on the basis of reasonable costs.

B. Data on Current RAP Services and Charges

The data used in the CRS study rely on the 1984 Part B Medicare Data (BMAD) and 1984 Patient Bill (PATBILL) files maintained by HCFA. The first section relies on the BMAD Summary Procedure File, which details the frequency, submitted charge, and paid amount for every procedure billed to Medicare by specialty, locality, and place of service. 1/ The second section which presents information about charges for RAP services during a hospital stay, relies on a merge of the BMAD beneficiary file and the PATBILL file. The time overlap for these two files was the period between January 1, 1984 and September 30, 1984, and the hospital stay analysis covers that time period.

The Medicare data files do not enable us to identify that portion of RAP services paid through the hospital under the part A program. For example, the files do not separately identify a considerable portion of inpatient clinical pathology services. They also do not separately identify amounts paid for hospital-employed certified registered nurse anesthetists (CRNAs). Further, due to the interaction of certain legislative and regulatory changes, the customary charges for certain physicians, previously compensated through the hospital under combined billing arrangements, tend to be low in 1984. Subsequent legislative changes addressed this issue.

1. Total RAP Services and Reasonable Charges

The volume and reasonable charges for all RAP services (in all places of service) are considerably higher than the volume and charges for these services provided just by RAP specialists. While RAP specialists' reasonable charges

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1/ Information from carriers not using the HCFA Common Procedure Coding System (HCPCS) was deleted from all the data files. Four carriers, covering seven States, did not use the HCPCS in 1984. They were: Prudential (New Jersey, Georgia, North Carolina), Texas Group Medical (Texas), Michigan Blue Cross-Blue Shield (Michigan), Iowa Blue Shield (Iowa), and Utah Blue Shield (Utah). In addition, some carriers that did use the HCPCS used non-HCPCS codes for some types of services. These were also deleted from the files.

for RAP services in the data base totaled about $1.8 billion, total reasonable charges for all RAP services were $2.9 billion.

Table 1 shows the frequency, total reasonable charges and average reasonable charges for the major groups of RAP services. Radiology services account for about half of all RAP charges. The other half of the reasonable charges for RAP services were about evenly split between anesthesia and pathology. While physicians performed half again as many pathology services as radiology services, the higher average charge-per-service for radiology resulted in the higher total radiology charges.

TABLE 1. Total RAP Services and Reasonable Charges a/

Type of service	Number of services (millions)	Total allowed charges ($ in millions)	Average allowed charges per service
Anesthesiology	b/	$687.1	b/
Pathology			
Clinical pathology	68.5	545.6	$ 7.96
Surgical pathology	4.3	130.8	30.27
Anatomic pathology	2.0	18.1	9.02
Miscellaneous pathology	1.1	10.3	9.61
Radiology			
Diagnostic radiology	41.1	1,046.7	25.42
Radiotherapy	3.4	155.2	45.98
Diagnostic ultrasound	2.3	160.5	69.15
Nuclear medicine	2.2	118.4	53.56
Total	b/	$2,872.7	b/

a/ Data from carriers not using HCFA Common Procedure Coding System were excluded. These carriers were: Prudential (New Jersey, Georgia, North Carolina), Texas Group Medical, Michigan Blue Cross-Blue Shield, Iowa Blue Shield, Utah Blue Shield.

b/ An accurate count of Anesthesiology services is not possible using the BMAD data. Anesthesia charges are for relative value units, not individual procedures.

NOTE: Detail may not sum to totals due to rounding.

Source: Table prepared by CRS based on 1984 Part B Medicare Data Summary Procedure File.

2. RAP Services and Reasonable Charges by Physician Specialty

While anesthesiologists and radiologists perform most anesthesia and radiology services billed to part B of Medicare, pathologists do not bill for most part B pathology services. Of the $690 million in allowed anesthesiology charges in 1984, anesthesiologists billed 92 percent ($632 million). The balance was billed primarily by surgeons of various specialties. Radiologists performed 75 percent of the diagnostic radiology, 78 percent of the nuclear medicine, 88 percent of the radiotherapy, and 47 percent of the diagnostic ultrasound services billed to part B. Radiologists billed for 68 percent of the total $1.5 billion in allowed radiology charges. The percentages of charges billed by radiologists ranged from almost 90 percent of the radiotherapy to just over 30 percent of the diagnostic ultrasound.

Pathology specialists accounted for nearly 10 percent of pathology services and 15 percent of the reasonable charges. Clinical pathology services dominate the pathology services and charges, and pathologists perform only 2.5 percent of the services billed to part B of Medicare. Part of the explanation for this low percentage is that pathologists tend to be hospital based and their contributions to clinical pathology tend to be covered under part A of Medicare. Much higher percentages of the anatomic and surgical pathology are

performed by pathology specialists. Independent labs and internists account for much of the part B covered pathology services.

3. RAP Services by Place of Service

Table 2 shows the distribution of RAP charges by place of service. Forty-seven percent of all RAP reasonable charges ($1.3 billion) were for inpatient services, but there was considerable variation in the share of charges for inpatient services based on type of service. Over 90 percent of anesthesiology charges, but only 2.5 percent of the clinical pathology charges were for inpatient services. Inpatient place of service was also common for nuclear medicine (62 percent), surgical pathology (58 percent), anatomic pathology (49 percent) and diagnostic radiology (42 percent).

TABLE 2. Total RAP Reasonable Charges by Place of Service a/
(millions of $)

Type of service	Home/ office	Independent lab	Inpatient	Other	Out-patient	Total
Anesthesiology	$ 6.6	b/	$644.7	$2.9	$ 32.9	$687.1
Pathology						
Anatomic	4.1	3.3	8.9	b/	1.8	18.1
Surgical	19.6	18.1	75.9	b/	17.1	130.8
Clinical	287.7	236.1	13.9	5.5	2.4	545.6
Miscellaneous	5.2	4.1	.7	b/	.1	10.3
Radiology						
Diagnostic	399.5	1.9	443.7	27.1	174.4	1,046.7
Radiotherapy	55.6	b/	25.9	.3	73.4	155.2
Nuclear medicine	17.2	.6	73.8	.7	26.0	118.4
Ultrasound	88.1	1.2	51.6	.5	19.0	160.5
Total	$883.6	265.4	$1,339.2	$37.3	$347.0	$2,872.7

a/ Data from carriers not using HCFA Common Procedure Coding System were excluded.

b/ Less than $100,000.

NOTE: Detail may not sum to totals due to rounding.

Source: Table prepared by CRS based on 1984 Part B Medicare Data Summary Procedure File.

Anatomic and clinical pathology, diagnostic radiology and ultrasound, and radiotherapy were often performed in physicians' home/office. The home/office place of service accounted for almost one-third ($884 million) of RAP reasonable charges.

A significant amount of radiology was performed on an outpatient hospital basis, with 47 percent of the radiotherapy, 22 percent of the nuclear medicine, and 17 percent of the diagnostic radiology charges billed as outpatient services. The outpatient setting also was the only other significant location for anesthesia services, accounting for over 5 percent of anesthesia charges.

4. Inpatient RAP Services by Specialty

RAP specialists perform a greater share of inpatient than total RAP services. While anesthesiologists, radiologists, and pathologists accounted for 61 percent of total allowed RAP charges, they accounted for almost 90 percent of inpatient RAP charges. With the exception of clinical pathology (52 percent) and diagnostic ultrasound (56 percent), RAP specialists bill for over 80 percent of all types of radiology, anesthesiology, and pathology charges (see table 3).

TABLE 3. Inpatient RAP Reasonable charges by Physician Specialty a/
(reasonable charges in millions of $)

Type of service	Specialty				
	Anesthesiology	Pathology	Radiology	Other	Total
Anesthesia charges	$597.6	b/	b/	$46.4	$644.7
Percent of charges	92.7	c/	c/	7.2	100
Pathology					
Anatomic charges	b/	$ 7.2	b/	1.7	8.9
Percent of charges	c/	80.6	.3	19.1	100
Clinical charges	b/	7.2	.3	6.4	13.9
Percent of charges	c/	51.9	2.1	46.0	100
Surgical charges	b/	61.7	.2	13.9	75.9
Percent of charges	c/	81.3	.3	18.4	100
Miscellaneous	b/	.6	b/	.1	.7
Percent of charges	.3	82.1	.6	17.0	100
Radiology					
Diagnostic charges	.2	.2	405.0	38.3	443.7
Percent of charges	c/	c/	91.3	8.7	100
Nuclear medicine	b/	2.6	61.6	9.6	73.8
Percent of charge	c/	3.5	83.5	13.0	100
Radiotherapy	b/	b/	23.1	2.7	25.9
Percent of charge	.2	.1	89.2	10.5	100
Ultrasound	b/	b/	28.9	22.6	51.6
Percent of charge	.1	.1	56.1	43.7	100

a/ Data from carriers not using HCFA Common Procedure Coding System were excluded.

b/ Less than $100,000.

c/ Less than .1 percent.

NOTE: Detail may not sum to totals due to rounding.

Source: Table prepared by CRS based on 1984 Part B Medicare Data Summary Procedure File.

5. RAP Services During Hospital Stays

In 1984, an average of a little more than three RAP procedures were performed during a hospital stay, with the average reasonable charge per stay of $144. Part B RAP services, however, were not billed for all hospital stays: 17 percent of all hospitals stays did not have a part B bill for a RAP service in the data base used for this study.

Among RAP services, radiology was the most common during hospital stays (occurring during three-fourths of all stays) while few radiotherapy procedures were billed. Eighty-three percent of the hospital stays on our data file had at least one RAP Procedure Billed. the corresponding figure for radiology was 76 percent,for anesthesiology and pathology 23 percent.

The average charge of $144 should be viewed in the context of how charges are dispersed about it. There is a great deal of variability in total RAP charges billed for hospital stays: almost one-fifth of stays have no RAP charges, most of the remaining stays have charges less than $100, and there are a few very expensive stays. Thus, the $144 average charge may not represent a "typical" stay. Alternative statistical measures, such as the median (the 50th percentile ranking) of charges, may better represent "typical" stays. In 1984, the median total reasonable charge for RAP services during stays was $54.72.

The average total RAP charges for hospital stays with at least one RAP procedure was $174.

RAP charges also vary depending on the geographic location and teaching activity of the hospital. Average reasonable charges were higher in the Pacific region (that includes Alaska and Hawaii) than in others, and higher in teaching hospitals than in hospitals without teaching activity.

6. The Association of RAP Charges per Hospital Stay and Patients' DRGs

The wide dispersion of RAP charges means that, paying for a bundle of inpatient RAP services based on the national average for all stays, would result in very different payments for these services than are made under the current system. If, however, RAP charges are related to patients' DRG classifications, using the DRG as a basis of payment could result in less difference in payments under such a new system.

Statistically, patients' DRGs explain 37 percent of the variation in total RAP reasonable charges per hospital stay. As indicated by the statistic, there is a relationship between DRGs and RAP charges, though there is a great deal of variation attributable to factors other than patients' DRGs. Some caution should be used when interpreting this statistic: it is a measure of how strongly RAP charges under the current payment system are related to patients' DRGs; it does not measure how well a RAP/DRG system would achieve various policy goals. The proportion of the variation explained by DRGs is very sensitive to the presence of "outlier" cases; that is, atypical, expensive cases within each DRG. If within DRG outliers are removed from the analysis, the proportion of the variation explained rises. This is shown in table 4.

TABLE 4. Percent of The Variation of RAP Reasonable Charges Explained by Patients DRGs

	Percent of variance explained
All hospital stays	37%
Less 1 percent most expensive cases within DRGs	43
Less 5 percent most expensive cases within DRGs	51
Less 10 percent most expensive cases within DRGs	56

Source: Estimates prepared by the CRS based on data from the (HCFA's) Calender Year 1984 BMAD and Fiscal Year PATBILL data files. Represents hospital stays occurring from January 1 to September 30, 1984.

The association between RAP reasonable charges and DRGs was also examined separately for medical and surgical DRGs. The association between RAP charges and DRGs is stronger in the surgical DRGs than in the medical DRGs: 27 percent of the variation of RAP charges within surgical DRGs is explained by DRGs, compared with 11 percent for medical DRGs. In fact, the division between medical and surgical categories accounts for some of the overall explanatory power of DRGs for RAP charges. This is true because part B pathology and anesthesia services tend to be associated with surgery. For example, only 5 percent of cases within medical DRGs were matched to a part B anesthesia bill, compared with almost three-fourths of cases within surgical DRGs.

7. Factors Other Than DRGS That May Help Explain RAP Charges

It is not surprising that DRGs explain only a portion of reasonable charges for RAP services during hospital stays. Some of the variance left unexplained represents pricing differences between physicians; additional

variation reflects that some patients within the same DRGs may receive more and/or more expensive RAP services.

Physician pricing differences, geographical location and teaching activity also have some relationship to RAP reasonable charges. Including these factors with DRGs in the analysis raises the percent of the variation in RAP charges explained to 44 percent (including outliers in the analysis), still leaving over half of the variation unexplained.

C. Objectives and Incentives of a RAP/DRG Reimbursement System

1. Incentives

A RAP/DRG payment system would create financial incentives due to the shift of some financial risk from the Medicare program to the entity receiving the payments. This financial risk, in turn, strengthens the incentive to control the cost of total services rendered. That is, a RAP/DRG payment methodology may impose financial risks on providers that encourage controlling of the total costs of RAP services per case, while reflecting variations in costs related to medical treatment.

There are a variety of responses that the health care system could make to a financial incentive to reduce the total cost of RAP services rendered during an inpatient episode. Depending on the responses made by individual institutions and physicians, these responses will either help to achieve the overall objectives for reform in physician reimbursement, or will worsen the current situation. The system could respond by:

--reducing the overall volume of services per episode of illness. That is, if these services are now overutilized, some amount of this overutilization could be eliminated. On the other hand, to the extent that currently provided services are appropriate, issues related to the quality of care may be raised.

--reducing the volume of services provided within the RAP bundle; that is, rather than ordering and providing these services on an inpatient basis, they could be performed in outpatient settings prior to or following the inpatient episode.

--seeking lower cost substitutes. This could include finding different mixes of services whose total costs are less than current patterns of practice. This could also include using lower cost substitutes for the relatively expensive input of physician specialists.

--reducing the price of professional services; that is, the current amount per service (or effective hourly rate) paid to radiologists, anesthesiologists or pathologists.

--increasing production efficiency; that is, reduce the non-professional input costs and the physician input time per unit of service.

--avoiding cases within certain DRGs, or avoiding certain cases within any DRG, if these cases are viewed as representing substantial financial risk to the entity receiving the RAP/DRG payment.

Whether or not a RAP/DRG system achieves the overall objectives of physician payment reforms depends, in part, on which of these responses occur, and to what extent. However, the probability of each response occurring depends on who is given the RAP/DRG payment, and on the ability of the entity receiving the payments to bring about a particular response.

2. Objectives of Reform and RAP/DRGs

Without a detailed proposal, it is not possible to determine the probable impact of a RAP/DRG system. The following discussion briefly considers four potential goals of a RAP/DRG system and identifies the major design options that would have an impact on their attainment.

a. Control or reduce expenditures under the Medicare program. A RAP/DRG system could provide increased control over Medicare expenditures for inpatient RAP services. A RAP/DRG system may also create downward pressure on the prices of some services and may reduce the volume of RAP services provided to hospital inpatients. However, whether these changes would generate savings for the Medicare program, and if so how much, depends on several factors including:

--the level of the initial payment rates and on how the RAP/DRG rates are updated from year to year compared to current law increases.

--the exact specification of the bundle of services included within the RAP/DRG payment. A larger bundle could increase the savings.

b. Control or reduce beneficiary liability for covered services. How beneficiaries would fare financially under a RAP/DRG system is totally dependent on the exact design of the system. Their total liability (including liability for charges in excess of reasonable charges) could increase, decrease, or stay the same, both in aggregate and for individual patients. Design issues that would be important in determining beneficiary liability include: the level of RAP/DRG payments; whether assignment would be mandatory or voluntary; if assign-ment is voluntary, how the liability for excess charges would be calculated; and how coinsurance liabilities would be calculated.

c. Encourage appropriate patterns of care and promote quality of care. If payment were made to either the hospital or a RAP medical group, a RAP/DRG system would have little effect on patterns of use of these services. Whatever small effect was achieved would be obtained as a byproduct of attempts to reduce the volume of tests and procedures in lieu of being forced to accept price reductions. Efforts in this direction would be limited by the ability of the hospitals and hospital-based physicians to influence the behavior of the attending physicians. Some of the potential responses to a RAP/DRG system could lead to less appropriate patterns and lower quality of care. In particular, avoidance of medically necessary tests and procedures or a shift of services to outpatient settings would reduce the quality of care. The risk of these responses may be greatest if the payments were given to the attending physicians.

d. Promote, or maintain, access to care. A RAP/DRG system could affect some beneficiaries' access to care. However, the impact on access is difficult to assess. In the short run, access would be reduced if physicians deserted Medicare beneficiaries for the potentially more lucrative care of non-Medicare patients. Access to RAP specialists in rural areas might also be affected, but this would depend somewhat on the system's design. For example, if the RAP/DRG system was modelled after PPS and had separate urban and rural payment rates, rural hospitals could be "outbid" by urban hospitals for the services of RAP physicians.

D. DESIGN ISSUES

A RAP/DRG reimbursement system is based on fixed payment amounts for cases within DRG classification catagories. The core of a RAP/DRG system is a set of relative weights assigned to each DRG and a set of payment rates. In its simplest form, the reimbursement for a particular case would be calculated as the product of the applicable payment rate and the RAP/DRG weight. While the core of a RAP/DRG system is based on two simple components, implementation of such a system involves many additional steps, each of which may involve a variety of both substantive and technical issues.

1. Define RAP/DRG Payment Bundles

Specification of the services to be included in the RAP/DRG bundle involves a series of tradeoffs. As the size of the bundle increases, the potential savings and control over program expenditures also increase. On the other hand, larger bundles may increase the administrative complexity of the system as individual RAP/DRG payments might have to be distributed among a

greater number of physicians. A larger bundle could also increase the potential risk imposed on hospitals and physicians.

Although it is generally assumed that three types of specialists (or services) would be included under a RAP/DRG payment system, the system could be limited to only one or two of these groups. Alternatively, there may be other types of physicians or services that are primarily hospital-based and that could be added to the RAP/DRG payment unit.

2. Potential Standardization Adjustments

The existing data on total charges per case reflect variations in physicians' prices and practice patterns. Such variations may be systematically related to geographic region, urban or rural location, teaching activity, cost-of-living, and special characteristics of the hospitals (e.g., teaching, disproportionate share, sole community providers and rural referral centers).

With respect to each such factor, there are three general questions. First, is the factor systematically related to variations in the total cost or charges of RAP services included in the bundle? Second, given the potential incentives of a RAP/DRG system, would it be more reasonable to reflect these systematic variations in the RAP/DRG payment amounts and perpetuate these differentials, or should these variations be subjected to the incentives of a prospective payment system? Third, if a factor is systematically associated with variations in costs and charges and if such variations are considered reasonable, how should the RAP/DRG payments reflect the observed relationship? The analysis in the CRS report suggests that geographic location, price inflation, urban/rural location, and teaching activity are related to total RAP reasonable charges per case. However, these factors account for only about 7 percent of the variance in reasonable charges.

3. RAP/DRG Weights and Rates

The set of RAP/DRG weights is in essence a case-based relative value scale of the total costs or charges associated with the care of patients between DRGs. The weights can be computed in several ways, for example as the average adjusted charges per case (assuming either a geographic price or teaching adjustment) in each DRG divided by the average adjusted charges per case across all DRGs, or a similar measure based on the costs of providing the services. In addition to many technical issues involved in the estimation of these weights and rates, a major design issue is whether the RAP/DRG system should be designed around a single national rate or whether it should be based on two or more rates, such as separate rates for patients in urban and rural hospitals. In addition, if the payments that would result from a particular design differ substantially from existing payments, it may be desirable to consider the need for a transition policy.

4. Outlier Issues

A prospective payment system based on DRGs assumes that the fixed payment amount represents a reasonable payment for a typical case within each DRG. That is, if a hospital or physician was only involved in the care of typical cases, then the average costs or charges of treating these cases would equal the payment rate over time. However, not all cases are typical. The actual distribution of total RAP reasonable charges per case varies substantially. While some of this variation is explained by various factors (DRGs, price, teaching, urban/rural location, and region), our analysis has indicated that the majority of variation in reasonable charges per case remains. In the absence of any special provisions, this risk is limited only by hospitals' and physicians' behavioral responses to the incentives, such as avoidance of potentially expensive cases, or by averaging the risk over a large number of cases.

An outlier policy may limit the risk imposed on hospitals and physicians by providing for additional payments for cases identified as being unusually expensive, usually referred to as "outliers." An outlier policy also may reduce the incentive for hospitals and physicians to avoid these cases. The analysis suggests that outlier cases may represent a large proportion of the

existing variance in reasonable charges and, thus, may be an important consideration in the design of a RAP/DRG system.

5. Beneficiary Cost-sharing

Under a RAP/DRG system, total beneficiary liability per stay could go up, down or stay the same, both in aggregate and for individual patients, depending on how the system is designed.

It may be that the basic concept of coinsurance charges is not consistent with the logic of a RAP/DRG payment system. That is, coinsurance requirements impose a financial burden on beneficiaries to discourage excessive utilization and to encourage the use of less costly providers. However, a RAP/DRG system in part is based on the argument that beneficiaries have little if any control over the price or volume of inpatient RAP services they receive. Given this argument, it may be reasonable under a RAP/DRG system to seek alternative sources of financing for the amounts currently accounted for by coinsurance charges. That is, Medicare could pay the full RAP/DRG payment amount, while any increases in program payments could be offset by increasing revenues from other sources, such as an increase in the inpatient hospital deductible or through an increase in the part B premium.

If the current coinsurance policy was applied directly to the RAP/DRG payments, beneficiaries would be liable for 20 percent of the RAP/DRG payment amount. Because the RAP/DRG payment represents an average across all patients in the DRG, this approach would cause some shifts in liability among beneficiaries, particularly as some beneficiaries use no part B RAP services during their inpatient stays.

A second issue related to beneficiary liability is the question of assignment. For a RAP/DRG system, a policy of voluntary assignment raises several issues. First, voluntary assignment would increase the administrative complexity of a RAP/DRG system as the current claims processing system may have to be maintained to estimate beneficiaries' liability for the so-called "excess charges." Second, a system of voluntary assignment may create opportunities for physicians to "game" the system to maximize their revenues at the expense of beneficiaries. Third, retaining voluntary assignment would dilute the financial incentives of the RAP/DRG system.

Under a RAP/DRG system, mandatory assignment would avoid the problems created by a voluntary assignment, simplify claims processing, and possibly generate a small amount of administrative savings by reducing the overall number of claims that would have to be processed. It would, however, prevent physicians from maintaining their income levels by collecting excess charges from Medicare patients that are able to afford the higher charges.

Chairman STARK. Thank you both.

As I hear you both saying, it would be a rare case, if indeed not a highly unusual circumstance, under which a Medicare beneficiary selected his or her own RAP? Is that a fair statement?

Mr. ZIMMERMAN. I would agree with that.

Mr. CAHILL. Yes, Mr. Chairman.

Chairman STARK. And it would only be the exception that proves the rule that a Medicare beneficiary ever bargained or had the opportunity to bargain for a fee charged by a rap?

Mr. ZIMMERMAN. I would agree with that.

Mr. CAHILL. Yes, I would, also.

Chairman STARK. Would you say that it was equally rare, if not almost non-existent, that a primary care physician—and I would include in that the surgeon, if that was who a Medicare beneficiary would go to—ever negotiated fees other than annually, in some kind of a hospital contract, but on a per patient basis with a RAP?

Mr. ZIMMERMAN. While we did not specifically look for this, we did not see any evidence in our work that physicians were negotiating fees with RAPs. In fact, we saw very little evidence of hospitals doing it and they had contracts with RAPs.

Chairman STARK. Mr. Cahill, in your research?

Mr. CAHILL. We did not address that question. I would defer to GAO.

Chairman STARK. What, if anything, did you see in the medical delivery system that had any kind of a restraining influence on the fees charged by RAPs? Mr. Zimmerman?

Mr. ZIMMERMAN. The work we did, did not indicate that there were any real meaningful restraints being applied on the fees charged by RAPs.

Chairman STARK. Mr. Cahill?

Mr. CAHILL. Although we do not address it, as we stated before, it seemed that any competitive forces that may work in the more general physician area work less well with RAPs.

Chairman STARK. I am going to toss you one. It occurs to me that one area in which there might be some restriction, and I cannot quite think through how this would affect Medicare, is that other, more conscientious purchasers of service, the Blues in commercial insurance companies and labor unions and other groups, might negotiate and thereby set standards of fees in an area and Medicare just might be an accidental beneficiary or victim of that fee. Would that make sense to you, Mr. Zimmerman?

Mr. ZIMMERMAN. That could happen.

I might add that of the 48 possible cases that we observed—the 16 hospitals times 3 types of physicians—we found only one case where the hospital had placed an upper limit on what a RAP could charge. That was 6 percent over the prevailing. That was the only evidence we came up with in our work.

Chairman STARK. Did you ever see any evidence, in any of the cases you looked at—and I will want Mr. Cahill to comment—where there was any objective analysis in adjusting the fees charged to the income, or otherwise the ability of the patient to pay?

Mr. ZIMMERMAN. To my knowledge, I am not aware, but maybe Mr. Sayers knows.

Mr. SAYERS. We did not see any evidence of that.

Chairman STARK. Now, Mr. Cahill, I guess I would ask you the question of whether you thought that perhaps the other purchasers of medical services in an area might affect the fees charged? And second, did you ever see any evidence of anybody making any objective analysis of patient's ability to pay?

Mr. CAHILL. To your second question, not to my knowledge. To your first question, I have only anecdotal information we do not deal with it directly in our study. But in talking to an individual anesthesiologist in Massachusetts, he indicated that there was pressure on their prices from the Blue Shield organization, which covers I think he said 95 percent of non-Federal insured patients.

Chairman STARK. I am led to believe that in Massachusetts, under Blue Cross-Blue Shield, they cannot extra bill. So that Blue Shield might affect the reasonable rate, the rate usually charged in an area?

Mr. REUTER. That is correct.

Chairman STARK. What controls does HCFA have, if any, to hold down what is paid now?

Mr. ZIMMERMAN. I will ask Mr. Cantwell to respond to that.

Mr. CANTWELL. They have the UCR mechanism, under which there would be an allowable charge limit for the participating physicians.

Chairman STARK. How do we get to that? How is that set?

Mr. CANTWELL. Well, they use the customary, prevailing and reasonable charge mechanism, and they take the lower of the actual, customary and prevailing charges.

Chairman STARK. But——

Mr. CANTWELL. You are talking about the Medicare payment to the physician in this case?

Chairman STARK. To the RAPs.

Mr. CANTWELL. To the RAP.

Chairman STARK. Now we have just gone through the drill of there is not anybody out there bargaining.

Mr. CANTWELL. Let us divide them into two classes. You want to divide them into the participating and into the nonparticipating physicians. In the case of the participating physicians, they have agreed to accept the allowed or the reasonable charge as payment in full. So they will be bound or limited by the allowed charge.

Chairman STARK. I understand that.

Mr. CANTWELL. This is not the case with the nonparticipating physicians. The limit there will be the maximum allowable actual charge.

Chairman STARK. But now let us get to the——

Mr. CANTWELL. You asked me the easier question earlier, which is how do you get to the UCR limit.

Chairman STARK. I mean, Medicare just goes into an area and says this is what everybody is charging, therefore that is what we will pay, in essence.

Mr. CANTWELL. Well, it is among other factors the charge that is customary for the physician in question.

Chairman STARK. What I am getting at——

Mr. CANTWELL. The indexed prevailing——

Mr. REUTER. Mr. Chairman, it is based on historical charging patterns from the claims that the physician has submitted during some earlier period.

Chairman STARK. But there is no bargaining. I mean, the other docs are not bargaining. What I am trying to point out here is there is absolutely no limit to what the RAPs can charge and get reimbursed by Medicare.

Mr. CANTWELL. Well, not absolutely no limit. There is a limit, but it is historically determined.

Chairman STARK. But who sets it?

Mr. CANTWELL. The physicians did, historically.

Chairman STARK. Who sets it now?

Mr. CANTWELL. The historical charging patterns, limited by the MEI.

Mr. REUTER. When you talk about limits on increases and fees, you also have to first mention the MEI at this point as a limiting factor on how much these fees, the prevailing charges in particular, can increase from year to year, which is not determined based on historical charging patterns but rather is based on various price and economic indices.

Mr. ZIMMERMAN. I think what we are saying, I guess, is that the physicians basically determined what they would get and the government is pretty much going along paying for it, at this point in time.

Chairman STARK. And in this particular case, there has never been any, outside of perhaps the Blues in some areas or other quantity purchasers, but there has never been any constraint, nobody really to bargain with, outside of just sheer embarrassment, I suppose.

Mr. ZIMMERMAN. Well, the bargaining is an interesting point. I do not sense there is bargaining going on by the program. There have been freezes and constraints and things of that nature, but I do not sense that anyone has sat down to say what is this service worth and how much are we willing to pay for it. It has more or less been the historic performance of the physician in the area and what has been accepted by payers.

Mr. CANTWELL. There is also an additional provision that Medicare ought not to be paying more than the carrier is paying in the private lines of business.

Chairman STARK. Okay. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

I want to ask a rather broad question and see if either of the two groups have any thoughts on it. We have talked, earlier in this hearing, about the basic studies which are underway and of the hopes that at some future time we may be able to come up with a strategy different from the past, for the reimbursement of physicians under part B.

My concern is that we do not take a step now which we have to reverse later or which makes it hard to move later because we have established a certain direction. Let me give you an example of what I am talking about. Under TEFRA, we in effect eliminated hospital combined billing for pathologists. We certainly encourage them to bill separately.

Now we are coming back in 1987 and talking about some kind of a combined billing, maybe an actual combined billing, if the payments go to the hospitals. That is a reversal of policy of just a few years ago. One could conceive of a reimbursement mechanism which might grow out of the work of PhysPRC or the Harvard study that might change it yet again.

I just wonder, as you think of the choices which we may face 4 or 5 years down the road, whether you anticipate any problems? Do you have any cautionary notes for us in connection with the administration's proposal as it may impact on our ability to move more broadly towards a less expensive approach to reimbursement to physicians?

Mr. ZIMMERMAN. Mr. Gradison, I heard for the first time what I think the administration's proposal is going to be and I think I share the concern of Chairman Stark and others about just folding in in-patient care and ignoring the out-patient situation. So I think, if they go in the direction they are proposing, that is going to be a problem in itself.

The question of assignment, particularly for this category of physicians, or any physician that you are going to talk about folding into a DRG system, is a problem.

I guess my view of how to reform physician payment is to try not to come up with a universal solution that is going to work for all types of physicians, but rather try to come up with multiple solutions. If DRGs are the best way to go for these types of physicians, then fine. I do not think it is necessary that we come up with a solution that is going to work for all physicians and there will only be one solution.

So my advice is to keep our eyes open for multiple solutions and hopefully we can come up with a series that will meet the needs not only of the program but the beneficiaries and, of course, the provider community as well.

Mr. CAHILL. Mr. Gradison, most of your questions, I think, are questions of when there is adequate information and the timing of political decisions, and these are areas that are probably not appropriate for CRS to comment upon.

Our analysis does show that there are a number of responses that the medical community could make to a RAP-DRG system, not all of which would necessarily be in accord with the goals the Congress might have for such a proposal and that care would need to be taken in each of the design issues—I think Mr. Zimmerman mentioned some of those—in order to achieve goals that Congress agrees on.

Mr. GRADISON. Thank you. Thank you, Mr. Chairman.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Well, in a word, what is wrong with an administration proposal that would be embellished by assignment and include nonhospital based services of a like nature?

Mr. ZIMMERMAN. Again, I am not that familiar with the administration's proposal.

Mr. LEVIN. What is wrong with what you heard, plus mandatory assignment, plus like services performed outside the hospital setting?

Mr. ZIMMERMAN. I would say it would have some potential. It sounds like the general theme that people are talking about if they believe that a DRG based system for hospital based physicians is appropriate. You also have to consider assignment. You have to consider out-patient services. You want to make it complete so that we are not subject to games and manipulations and we do not pass the whole problem off.

Mr. LEVIN. I understand that, but I have added a few pieces to take care of that. I do not know if it is appropriate, within your function. If it is not, tell me. But it is often said from here, eventually there is a red button and a green button and a present button, which we try not to use.

If you add to the administration proposal mandatory assignment and a system that covers like services outside the hospital, what is wrong with it?

Mr. ZIMMERMAN. I think the big problem I have with the administration's proposal, is just who is going to get paid? I am not sure I know whether the money is going to go to the hospital, to the attending physician, or to the RAPs. I think all these three situations create different incentives and I think that is where I am having difficulty. And the administration is not sure either.

If you give the money to the hospital, then I think we have problems as to whether the hospitals are going to play more of a role than maybe the medical community and the program wants them to, in terms of making day to day decisions on what services should or should not be made available to the patients.

So I think the big problems, in my mind, with the administration's proposal, if you do the things that you were just talking about, Mr. Congressman, is who is going to get the money and how much? Those are the two unknowns.

Until someone comes up with some rationale and reasons, I think we are still going to have to guess at and wonder about those two points.

Mr. REUTER. If I may, in working through our analysis of the system, one of the almost truths that came out, if you will, is that exactly how the system may respond to the incentives that are included within this type of proposal is almost totally dependent upon the entire spectrum of design issues that you end up selecting.

You have suggested some choices about some of them, in terms of mandatory assignment, in terms of including services in the outpatient setting, but there are other things that would also affect those incentives. For example, how well would the various adjustments that you might impose on the payments match or not match current payments? How large would the financial risk be that is imposed on the providers—the entities receiving the payments—whether it is the hospitals or the physicians? The strength of those incentives would determine, in some degree, whether they would respond at all or be forced to respond in an inappropriate way.

I think that there are some questions, in terms of at least risk and distribution of payments, that have not been resolved yet and that, in some sense, should be looked at in considering this type of approach.

Mr. LEVIN. Thank you, Mr. Chairman.

Chairman STARK. Mr. Moody.

Mr. MOODY. Thank you.

Would your criticisms be the same or would they be substantially different if the administration's spokesman's characterization of the RAP, Inc. approach was adopted rather than various alternative forms?

Mr. ZIMMERMAN. As I recall that proposal, I think it was—correct me if I am wrong—the payment would go to the RAP, Inc.?

Mr. MOODY. Yes, they would set up their own institution. So your question about would it go to the hospital would be answered under that?

Mr. ZIMMERMAN. I would have to think a little bit more about it, frankly speaking, to draw a conclusion right now on it. I just have not had an opportunity to study that and I am not sure I know exactly what they mean when they say they will pay the RAP, and how the hospital will be involved in that. I am not sure what the relationship would be between the hospital and the RAP, Inc. if the RAF is going to collect the money.

Mr. MOODY. If you had a chance to think about it, maybe you——

Mr. ZIMMERMAN. I would be more than glad to. Let me say that once the administration comes forward with a position, GAO would be more than glad to give you our comments and thoughts on it, however you should desire, whether it be by letter or whatever circumstance or situation.

Mr. MOODY. A second ago you said, in response to Mr. Levin's question, that your problem at this point is you do not know where the money is going to go, who is going to get it. Is it the question that you do not like uncertainty or you fear that the salaries of RAP physicians will be lower? What is the bedrock problem? Is it the uncertainty element or do you feel that the bottom line——

Mr. ZIMMERMAN. I think my problem is the incentive. I am concerned about who is going to worry about collecting the money and therefore, who is paying for the services, and I am concerned with the incentive element.

We do not want to create perverse incentives in the system to the detriment of the program or the beneficiaries.

Mr. MOODY. Will who collects the money affect medical decisions?

Mr. ZIMMERMAN. I think it could.

Mr. MOODY. Could you walk through that a bit with me, just briefly?

Mr. ZIMMERMAN. Well, I think that if the hospital is going to collect the money or incur the cost, then there is a risk to them and they will probably exert pressure on the provider to minimize their liabilities or costs. As far as I am concerned, the incentive would not necessarily be to make sure that the patient's needs are being met, but would also include a major incentive to make sure that the costs are being kept down to the minimum necessary to meet the needs of the beneficiary. And that may not always be the best case for the beneficiary.

Mr. MOODY. I asked that question in a different form to their spokesman and he said he had confidence in the medical profession that they would do what was right for the patient. He did not feel there would be an erosion of quality, but you fear there would be?

Mr. ZIMMERMAN. Well, that is his opinion. He is a representative of the—presumably one of the provider groups.

Mr. MOODY. But he based it on the faith in your profession.

Mr. ZIMMERMAN. I am not a physician.

Mr. MOODY. Okay, in the physician's profession.

Mr. ZIMMERMAN. Well, that may be the case, but if the physician is not paying the bills and the hospital is, maybe the hospital administrator has other ideas, other than the commitment the attending physician has to his or her profession.

Mr. MOODY. He may not be a physician either.

Mr. ZIMMERMAN. That is true.

Mr. MOODY. Okay.

Mr. ZIMMERMAN. I hope the physician is a physician, though. [Laughter.]

Mr. MOODY. Thank you very much.

Chairman STARK. Just one final question. If patients basically do not have the opportunity to select a RAP who participates or who will accept assignment, then can either of you see, in the process, any reason to allow extra billing, balance billing?

Mr. ZIMMERMAN. In this case of RAPs, I would have to agree it is a questionable arrangement to allow balance billing. The concept of assignment suggests choice. Choice on both parts. Choice on the part of the physician to decide whether or not he or she is going to accept assignment, and choice on the part of the beneficiary or the patient.

I do not see that choice element existing in the RAP situation, to a large degree, so I question whether the concept of assignment and the ability to choose on both parties exists. Therefore, I question the concept.

Mr. REUTER. I think there is a couple of comments that can be made, both pro and con, on the assignment issue. First, I think that having a voluntary assignment system would make the administration much more complex as you would have to maintain the part B claims processing function for the inpatient RAP services.

Second, I think that a voluntary assignment system would create some opportunities for physicians to game the system. That is if they could try to maximize their revenues. And third, I think that voluntary assignment would really dilute the financial incentives of the system. That is, physicians could effectively ignore the system's incentives and maintain their revenues by reducing the frequency with which they accept assignment.

Of course, on the other hand, the primary advantage of voluntary assignment, at least to some extent, is that it does limit the financial risk that would be imposed on providers and physicians. And if we are not certain about what that level of risk is, then perhaps we ought to give them some protection for that.

Chairman STARK. What if we took away the risk?

Mr. REUTER. If you take away the risk, then I think that the arguments in favor of a voluntary assignment system become somewhat weaker.

Mr. ZIMMERMAN. I would have to agree with that.

Chairman STARK. Got one more?

Mr. MOODY. One brief question. I gather that these three professions are fairly high on the scale of physician income; is that correct?

Mr. ZIMMERMAN. I think out of the top four, they are three out of the top four.

Mr. MOODY. And we were told earlier in response to the chairman's question that these rates are basically set through historical practice. There is no one setting them except that historical precedent is the main guide.

If that is true, that they are so highly paid, what suggestions would you have for controlling cost and perhaps bringing those, if in fact they should be, more in line with skills that require comparable levels of cognitive and physical skill? If we do not do this or something like it, what do you suggest? What would be an alternative?

We have only historical precedent as this guideline and we know what that has left us with. In this case, some very highly paid physicans. Is there another way that would be better?

Mr. ZIMMERMAN. Let me say this, we have done no work that would yield information as to what the right fee should be for the various types of service that the RAPs provide. I think a combination of things enter into an income equation, not only the fee that is charged but the frequency of services, as well. I mean, there is a whole series of things that would enter into an equation of income.

And I am not prepared to say that RAPs are overpaid for the services they provide. All I can say is, they make more money than most physicians, and I am not prepared to go any farther.

Mr. MOODY. Would anyone here on the panel suggest that the RAPs are the three most demanding skills of all the physician skills? If you had to list all the specialties in terms of difficulty, intensity of training, skill levels and all the rest that presumably would go into a comparable value study, would anyone on the panel suggest that these would be three out of the top four?

Mr. ZIMMERMAN. I would not think they would be three out of the top four, but maybe someone else has an opinion to the contrary.

Mr. MOODY. Anyone there think they would be three out of the top four?

Mr. CAHILL. We do not have any information on that subject.

Mr. MOODY. No opinion? Anyone doubt that they would be three—anyone else doubt that? [Laughter.]

Chairman STARK. If the gentleman will just be patient for a few minutes, we will have some testimony from the horse's mouth.

Mr. MOODY. I am not asking in a contentious way, I really do not know. I am just an economist.

Mr. ZIMMERMAN. I think in our testimony we point out the return on training, which I guess amounts to their investment and time and so on, was higher, by and large, than most other physicians. So in essence, it says that they get more money back than a lot of other physicians do, given the amount of time they took to gain their training and knowledge.

Maybe Mr. Cantwell, has something he could add to that.

Mr. CANTWELL. I would call your attention to a longer version of our testimony. There are a number of characteristics of the RAP

marketplace that would tend to limit the ability of market forces to restrain fees. These characteristics include the prevalence of exclusive contract arrangements, which we discussed, and the fact that the RAP services and prices are not normally known beforehand by the patient. This set of circumstances can partly help explain why RAPs earn such high incomes.

Mr. MOODY. And we know that market forces are difficult at best in the medical profession. But even the market forces that we sometimes can identify are largely absent in this case. Is that another way of expressing the same thing?

Mr. ZIMMERMAN. I would agree with that.

Mr. CAHILL. We would agree as well.

Mr. MOODY. Okay, thank you very much. Thank you, Mr. Chairman.

Chairman STARK. Thank you, gentlemen. Your testimony, as usual, is helpful and we appreciate it.

Our next witness is Dr. Janet Mitchell, the president of the Center for Health Economics Research.

Welcome, Dr. Mitchell, to the committee. The Chair apologizes in advance but I will have to be absent in a couple of minutes, I know not how long, for a meeting that I cannot avoid. And Mr. Moody and Mr. Gradison will stay, and I understand some other members will be returning.

So if I am absent at the end of your testimony, I apologize, as I must to the following panel. I may be back before the hearings are completed. But if you will accept that apology and proceed with your testimony in any manner that you are comfortable.

STATEMENT OF JANET B. MITCHELL, PH.D., PRESIDENT, CENTER FOR HEALTH ECONOMICS RESEARCH

Ms. MITCHELL. Thank you. I need to apologize because I have come down with laryngitis, but I will do my best.

I am happy to be invited back here again to speak about DRG-based payment for inpatient RAP services. And I would like to briefly summarize what I see as the two chief advantages.

First of all, it would introduce financial incentives to cut back on marginally necessary x rays and lab tests. If payment were to go to the hospital, it would reinforce existing PPS incentives.

Second, it would provide new opportunities to employ the most efficient mix of services, and to substitute non-physician staff where appropriate. By packaging anesthesia services, for example, each hospital and medical staff, depending on who got the payment, could make its own determination on when to use anesthesiologists and when to use CRNAs, certified registered nurse anesthetists, and in what amounts and on what cases.

Mr. MOODY. I am sorry to interrupt. Who would make that decision?

Ms. MITCHELL. Whoever received the payment. It might be a hospital, it might be a medical staff-based entity.

Now any case payment approach like RAP DRGs involves some sort of averaging. Some cases will require more RAP services, some cases will require less. But it is assumed that on average the DRG price will be a reasonable reimbursement for the services required.

Now for policy purposes, it is important to know just how this averaging plays out for individual hospitals or medical staffs. Are there systematic winners and losers?

My simulation analysis shows that over one-half of the hospitals we studied would receive windfall gain of $15 or more on every admission. A much smaller number, one-sixth of the hospitals, would lose this much or more on every case. The group most likely to win would be rural hospitals, and the group most likely to lose money would be teaching hospitals.

Why would rural hospitals do so well under this kind of system? One reason is their case mix. Rural hospitals admit somewhat less seriously ill patients even within a DRG. Second, and more important, is their practice patterns. Rural hospitals are more likely to employ CRNAs to administer anesthesia and these providers are simply less expensive than anesthesiologists.

Finally, and probably more important, rural hospitals are smaller facilities and as such they offer less specialized equipment. If you do not have a CAT scanner available, radiologists cannot perform a CAT scan and they cannot submit a bill for it.

Teaching hospitals would be more likely to lose money for reasons that go beyond their case mix and beyond the availability of specialized technology. And the reason is probably the extra diagnostic testing performed for teaching purposes, an added cost that is recognized by Medicare under the hospital PPS, but which was not accounted for in our simulations.

Now should an indirect medical education adjustment be made for teaching hospitals under any RAP DRG approach? I am not sure. Medicare part A has historically subsidized the teaching function that is implicit in this additional testing. However, it could be argued that non-resident physicians are already subsidized under part B.

Physicians in teaching hospitals are paid as if they personally performed all aspects of the billed service. But in fact, they may receive considerable assistance from residents in reading x rays, examining specimens, administering anesthesia and what-not.

There has been a lot of discussion already this afternoon about assignment, and I would like to address this issue explicitly. Voluntary, or case by case, assignment is simply inconsistent with the principle of averaging that underlies any case payment approach, whether it is the hospital prospective payment system or whether it is a RAP DRG case payment.

Physicians would take assignment on the easy cases and not accept assignment on the cases expected to be more difficult. In this instance the DRG payment becomes a floor rather than an average. This leaves Medicare with the worst of both worlds; paying the physician considerably more than necessary when the case is assigned, and the beneficiary paying considerably more out-of-pocket when the case is not assigned.

The solution would be to treat inpatient RAP services just like Medicare handles hospital care; the DRG rate would represent payment in full with the patient liable only for any copays. It makes sense to protect beneficiaries from balance billing given their inability to shop for RAP services based on physicians' willingness to accept assignment.

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As we know and have heard already today, while patients can actively select a family physician or a surgeon, they do not participate in the decisionmaking process that leads to the selection of a radiologist or an anesthesiologist or a pathologist.

Thank you.

[The prepared statement follows:]

Janet B. Mitchell, Ph.D.
President
Center for Health Economics Research
Needham, Massachusetts

Introduction

My name is Janet B. Mitchell. I am the President of the Center for Health Economics Research, a non-profit research firm in Needham, Massachusetts. Much of my research during the past decade has been devoted to issues of physician reimbursement under Medicare and Medicaid.

I would like to thank the Committee for inviting me to testify on the feasibility of DRG-based payment for inpatient radiology, anesthesia, and pathology (RAP) services. I have been studying alternative approaches to physician DRGs, including the so-called "RAP-DRGs," for the past three years and am pleased to share my thoughts with you.

Why Package RAP Services?

Medicare expenditures for physician services are the product of two variables: the fee per service and the number of services. Effective cost control can only be achieved by controlling both of these variables simultaneously. One way to do this is to package physician services: to make a single payment for a group of related services. The advantage to packaging is that it gives the physician an incentive to cut back on marginal services, since their costs must come out of the fixed package payment.

The Medicare Hospital Prospective Payment System, of course, is an example of the packaging of inpatient hospital services. A similar approach for the Part B program would be to package all inpatient Part B RAP services associated with an admission and make a single case payment, where the size of the payment is determined by the patient's DRG. Part B RAP services could be redefined as hospital services and paid through Part A under the current PPS. Alternatively, the package could constitute a separate Part B payment to the hospital, or to some other entity like the medical staff. Since patients do not choose their own radiologist, anesthesiologist, or pathologist, and hence cannot shop based on price or willingness to accept assignment, it seems more appropriate to include these physician services in the hospital bill. This approach would have two main advantages.

First, DRG-based payments for RAP services would introduce financial incentives to cut back on marginally necessary x-rays and lab tests. If the payment were to go to the hospital, it would reinforce already existing incentives under PPS. The hospital that reduces unnecessary testing would save not only the technical costs associated with performing the test but also the professional component of the bill associated with interpreting the test.

Second, this approach would provide new opportunities to employ the most efficient mix of services and to substitute non-physician staff where appropriate. The costs of hospital-employed Certified Registered Nurse Anesthetists (CRNAs), for example, are currently a pass-through under PPS, until a decision is made in Congress next year (although CRNAs may bill Part B directly beginning in 1988). By packaging anesthesia services into a DRG-based rate, each hospital or medical staff could make its own determination on when to use anesthesiologists versus CRNAs.

Does DRG-Based Payment Make Sense?

A unique data base was created: Medicare hospital and physician claims merged at the admission level. Part A and Part B data were obtained for 1984 from four states: Alabama, Connecticut, Washington, nd Wisconsin, totalling over 650,000 hospital episodes. While these data are not representative of the U.S. as a whole, they have a distinct advantage over those national studies that are based (by necessity) on only a sample of beneficiaries. The availability of data on all admissions permits analyses at the hospital level, including simulation of potential redistributive effects.

Radiology, anesthesia, and pathology services were defined based on their procedure codes, regardless of the specialty of the physician providing them. Inpatient Part B RAP charges were defined as the sum of reasonable charges (including patient copays) for all RAP services provided during the hospital stay. All charges were adjusted for geographic cost of living differences, using the PPS hospital wage index.

The Part B RAP bill ranges from about $50 to over $1,000 per admission, with surgical DRG cases averaging about three to four times higher than medical admissions. More important for policy purposes than average charge levels, however, is the variation around each mean, for this indicates the

likelihood that a DRG-based case payment will in fact reflect actual RAP charges. Surgical DRGs are quite homogeneous with coefficients of variation (CVs) of 0.50 or lower, implying relatively little variation in RAP charges. By contrast, medical DRGs vary dramatically with CVs exceeding 1.0, suggesting that hospitals (or medical staffs) would be either underpaid or overpaid in nearly every case.

Why do we observe so much more variation in Part B RAP charges for medical DRGs? The main reason probably lies in the extent to which certain RAP inputs are fixed or non-discretionary. Surgical DRGs always include a charge for anesthesia services, and anesthesia accounts for over one-half of the total RAP bill. There are no fixed inputs for medical DRGs, on the other hand; patients receive varying amounts of Part B RAP services, and some none at all. Does the limited ability of DRGs to predict RAP charges for medical admissions mean that this system is not adequate for Part B reimbursement? Not necessarily. Similar results have been found for hospital costs, yet PPS has been generally acknowledged a success, probably for two reasons. First, hospitals are able to average large numbers of cases across all the medical DRGs, offsetting large losses on a few very sick patients with small gains for the majority of healthy patients. Second, PPS includes a number of adjustments, including extra payments for outliers, that help capture unmeasured sources of casemix variation. Presumably, similar adjustments could be made for RAP payments.

Redistributive Effects Across Hospitals

Any case payment approach like RAP DRGs involves some sort of averaging. It is assumed that some cases will require more RAP services and some cases will require less, but that on average the DRG price is a reasonable reimbursement for the services required. This assumption may not be valid, however, if certain types of hospitals are consistently over or under the mean, holding DRG mix constant.

How would hospitals fare under case payment for RAP services? Simulation analyses show that the average hospital actually would make money. In fact, over one-half of the hospitals studied would receive windfall gains of $15 or more on every admission (relative to a case average of $148), while a much smaller number (16%) would lose this much or more on every case.

Although the majority of hospitals would be winners, there are definite systematic differences in redistributive effects by hospital type. The groups most likely to win and lose are rural hospitals and teaching hospitals, respectively. Why would rural hospitals fare so well under DRG-based payment for RAP services? There appear to be three main reasons. First is their casemix; rural hospitals admit somewhat less seriously ill patients within-DRG, e.g., fewer PPS outliers, fewer transfers, etc. The second reason is their practice patterns. Rural hospitals are more likely to employ CRNAs to administer anesthesia, and these providers are less expensive than anesthesiologists. The third, and probably most important, reason has to do with available technology. As smaller facilities, rural hospitals simply offer less specialized equipment. Without CAT scanners available, for example, radiologists cannot perform (and submit bills for) these tests.

Why teaching hospitals would lose money under RAP DRG case payment is somewhat more of a puzzle. Even after adjusting for casemix severity, bedsize, CRNA use, and other variables (most of which would not be included in any prospective reimbursement system), teaching hospitals would incur a net loss on every case. One obvious explanation is the extra diagnostic testing performed for teaching purposes, an added cost recognized by Medicare under the hospital PPS but not taken into account in the simulations. Should an indirect medical education adjustment be made for teaching hospitals under any RAP DRG program? The answer is unclear. Medicare Part A has historically subsidized the teaching function implicit in the additional testing. However, it could be argued that (non-resident) physicians are already subsidized by the Part B portion of Medicare for RAP services. RAP physicians in teaching hospitals are paid as if they personally performed all aspects of the billed service, but, in fact, they may receive considerable assistance from residents in reading x-rays, examining specimens, etc.

The Issue of Assignment

Voluntary assignment is inconsistent with the principle of averaging that underlies any case payment system, including "RAP DRGs." Assignment would be taken on the easy admissions (those expected to be less costly to

treat than the DRG payment) and not accepted on those expected to be more difficult. The DRG payment becomes a floor rather than an average, thus undermining the whole concept of risk-sharing. Such an outcome would leave the Medicare program with the worst of both worlds; paying the physician considerably more than necessary when the case is assigned and the beneficiary paying considerably more out-of-pocket when it is not.

The solution would be to treat inpatient Part B RAP services just like Medicare handles hospital care; the DRG rate would represent payment-in-full for all services with the beneficiary liable only for any deductible and coinsurance. It makes sense to protect beneficiaries from balance billing given their inability to shop for inpatient RAP services based on physicians' willingness to accept assignment. While patients can actively choose a family physician or surgeon, they do not participate in the decision-making process that selects a radiologist, say, or an anesthesiologist. While radiologists and pathologists have signed the Medicare participation agreement in above-average numbers, the participation rate for anesthesiologists is one of the lowest of any specialty, a fact that raises the total cost of surgery for many Medicare patients.

Mr. MOODY. Thank you. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman. Thank you, Dr. Mitchell.

How would you structure this if it were up to you? Who would you give the money to? Do you have any other thoughts on structuring?

Ms. MITCHELL. If it were up to me, I would pay the hospital. That does not necessarily mean that the payment would be folded into hospital PPS. If you wanted to keep it a separate part B payment, that part B payment could then go to the hospital.

Mr. GRADISON. Do not some hospitals currently have salaried arrangements with certain physicians in these specialties, in your State, for example?

Ms. MITCHELL. They have salaried arrangements primarily for the administrative and supervisory capacities that these physicians perform. Medicare requires that those activities that are billable under part B be billed to part B.

Mr. GRADISON. Prior to TEFRA were there many contractual relations of a salaried nature that you know of with those actually performing any of these three services, for example in your State?

Ms. MITCHELL. The evidence that is available pre-TEFRA shows that there was a wide mix of arrangements of which salary was one, and not necessarily the most dominant one.

Mr. GRADISON. Was there any evidence one way or the other that you know of that the use of a salaried arrangement had an impact on access or quality of care?

Ms. MITCHELL. There are no studies that I know of. I would like to make one comment, because I think I know what you may be suggesting. I would like to point out that giving the payment to the hospital does not make RAP physicians salaried. The last thing the hospital wants to do is to be responsible for physicians' salaries.

Instead the hospital would negotiate contractual arrangements with the RAP groups as each party thought was most appropriate for their situation. In many instances this could continue to be business as usual. It could continue to be fee for service, presumably a discounted fee for service in return for the exclusive contract, or it could be a case payment arrangement.

The advantage to the approach is that you would let each hospital and RAP physician groups make their own arrangement, whatever was most appropriate for their particular community and patient mix.

Mr. GRADISON. I appreciate your responses. Let me just say to my colleagues on the committee that in my conversations with people who are especially interested in this issue, the only group that I have found that is more strongly opposed than the radiologists, anesthesiologists and pathologists to this proposal is the hospitals that might be in the middle. They are saying they have enough trouble.

They think that even if the payments in the first year are adequate, they are likely to get squeezed down later on, and that they are having enough trouble making a go of it with the DRGs without being expected somehow to finance additional services from what they consider to be a diminished pool of funds.

Thank you so much. Thank you, Mr. Chairman.

Mr. MOODY. Thank you. Mr. Pickle.

Mr. PICKLE. Mr. Chairman, I have not had a chance to read of all of Ms. Mitchell's testimony. I do notice on page 4, Dr. Mitchell, with respect to rural hospitals you indicate that they would fare well, or that the rural hospital would be "winners," I believe you said, in the DRG system. But at the same time in your testimony you have also indicated that it is true that rural hospitals would not be using anesthesiologists or CAT scans at the same time.

To me that indicates you are saying they might be winners, but they will not get as good a quality of care. Is there not sort of an inconsistency in your position on that?

Ms. MITCHELL. No, I do not think so. Rural hospitals would do better under this system because their costs are lower. One of the reasons that the cost of providing RAP services in those hospitals is lower is because they tend to use disproportionately more CRNAs. CRNAs are used in all types of hospitals, rural and urban, teaching and nonteaching hospitals. They just happen to be used more in rural hospitals.

The availability or the nonavailability of specialized equipment in rural hospitals does in fact mean that there are services which patients do not have access to. Those patients presumably are transferred to hospitals which do have those services. Under the existing hospital prospective payment system we have that identical situation.

Mr. PICKLE. As I read this you list three different reasons why they might be winners, their case mix and practice patterns and available technology. That may or may not be true. On the one hand, you would say that their case mix and these other things makes it a little bit cheaper for them.

If, in the same breath, you would say they do not use anesthesiologists or CAT scans, it seems to me that they are not going to be getting as good a quality of care. And it seems to me like we would sacrifice one for the other. Now do you deny that?

Ms. MITCHELL. Well, it depends on whether you are willing to assume that there is a definite difference in quality of care between CRNAs and anesthesiologists. Many hospitals that employ CRNAs are administering anesthesia under the supervision of an anesthesiologist. It so happens that there are almost 1500 hospitals in this country that have no physician anesthesiologists and are forced to rely solely on CRNAs.

It is quite conceivable that a system which rewarded disproportionately those rural hospitals might attract some physician anesthesiologists into them to provide that care. But as of right now, the anesthesiologists simply are not there.

Mr. PICKLE. I notice you say that if you took the RAPs and you included them in the DRG system, that would introduce financial incentives—I believe that was your phrase—financial incentives to cut back on marginally necessary x rays. Now let us take that statement, just on the surface of it.

How do you determine what x rays are marginally necessary? Who makes that determination? Why would there be that incentive to reduce marginally necessary x rays?

Ms. MITCHELL. What the system would be doing would be building on the existing hospital prospective payment system, which al-

ready includes those incentives. If a hospital now does not provide an x ray, it saves the technical costs associated with providing that x ray. If the hospital were also to receive a part B payment, they would save the interpretative cost, the physician cost associated with that x ray.

Mr. PICKLE. You are saying then that, if a doctor was associated with a hospital, then they would take less x rays. They would save money and just would not use as many x rays; is that what you are saying?

Ms. MITCHELL. That is the financial incentive that is introduced.

Mr. PICKLE. What are you going to do if your doctor tells you that you may have cancer and he recommends another x ray to examine that more closely? Would you consider that marginal?

Ms. MITCHELL. The decision of whether the x ray is necessary or not is the decision of the physician. The idea is that because it is a packaged payment, it is based on an average. And built into that average is the expected probability that those services will be required.

Mr. PICKLE. It seems to me, and I am just trying to interpret your reasoning on this, you say that if you had a physician in the hospital under the DRG system and he was, in effect, part of the hospital operation, that they would then require less examination and you would save money. Is that what you are saying?

Ms. MITCHELL. The incentive would be to provide fewer x rays than are done now.

Mr. PICKLE. I would think you would want to have as many x rays as you think would be necessary, rather than just trying to save money, per se. If your doctor recommended more x rays, you would not object to that, would you?

Ms. MITCHELL. Which doctor are you talking about?

Mr. PICKLE. The doctor in the hospital.

Ms. MITCHELL. The x rays are ordered by the attending physician, who would be outside this payment system.

Mr. PICKLE. Maybe I have a different rural hospital system than you have in Massachusetts, but I do not think my hospitals feel that that necessarily follows. Perhaps if they were under the DRG system they would automatically feel like it was not necessary to have as many x rays and save a little money. I rather doubt that. They would order the number of x rays that they needed, and not do it on the basis of one system or another.

Ms. MITCHELL. I think it is very important to remember that we have had this system in place now for several years, and we have witnessed a dramatic decline in lengths of stays and associated ancillary costs.

Mr. PICKLE. You said we.

Ms. MITCHELL. The United States, the Medicare program.

Mr. PICKLE. You are not talking about Massachusetts?

Ms. MITCHELL. No, the Medicare program through the hospital prospective payment system.

Mr. MOODY. You mean DRGs as such have been in place for several years.

Ms. MITCHELL. Yes.

Mr. MOODY. Not the RAP——

Ms. MITCHELL. No, with hospital services. So that the incentives to cut back on x rays already exists. And a RAP DRG system builds on that, although I think somewhat marginally given the very strong incentives already in place under the hospital prospective payment system.

Mr. PICKLE. I will be interested, Mr. Chairman, to see what the RAPs would feel about it. There might be a difference of opinion.

Mr. MOODY. Okay, Mr. Levin.

Mr. LEVIN. Just quickly. There is always resistance to new ideas. You have been studying this area for 3 years. I take it you have no axe to grind. I do not know about the Center for Health Economics Research. How is that funded? Are you neutral?

Ms. MITCHELL. The Center for Health Economics Research is a non-profit-research company in Massachusetts. All of our work is public sector work. Most of our work is for the Federal Government, especially for HCFA.

I think it is worth pointing out that I testified before this committee last year and discussed the notion of DRG based payments for RAPs and HCFA was one of the groups most adamantly opposed at that time.

Mr. LEVIN. All right. Then what is the strongest—you studied this for 3 years—what is the strongest argument against your position? I mean, you seem to favor moving ahead with this with certain protections and factors built in, mandatory assignment, et cetera. If you shifted position for a minute, as a neutral observer of this, or less perhaps involved than some others, what is the strongest argument against moving this year?

Ms. MITCHELL. This year or at all?

Mr. LEVIN. This year.

Ms. MITCHELL. It would be hard to think of a reason.

Mr. LEVIN. It is that open and shut a case, do you think?

Ms. MITCHELL. Well, ideally I would like, and many people would like to see a demonstration project of these types of ideas. But we simply have never had any demonstration projects in the area of physician reimbursement, and time is marching on.

There is no question but that this approach, by packaging together physician services is a radical departure from the current fee for service system. So I think that would probably be the strongest argument against it, that it is a change.

Mr. MOODY. That it is different; that it is radically different.

Ms. MITCHELL. It is radically different in the sense that you are paying for a bundle of services based on the nature of the case, as opposed to the current fee for service system.

Mr. LEVIN. Would you feel sure enough of your position, knowing what you do, if you were on this side, to suggest a major demonstration project or that we simply move ahead?

Ms. MITCHELL. I would recommend moving ahead with the RAP services, but I would also be happy to see a demonstration project if it could be conducted adequately. But I think in this particular instance, because of the nature of the physician services that we are discussing, I am not sure what a demonstration project would tell you. Demonstration projects——

Mr. LEVIN. I do not know—that is somewhat inconsistent. You said you would prefer a demonstration project, but——

Ms. MITCHELL. As a rule. But I think it is much less necessary in the instance of RAP services than for an all-inclusive physician DRG program, which has been something that I have been studying extensively.

Mr. LEVIN. Okay, thanks.

Mr. MOODY. Thank you. Just a little bit more on your organization.

You are contracted with HCFA to do the study; is that right?

Ms. MITCHELL. This particular study, yes. It is a grant actually, not a contract.

Mr. MOODY. You are a health economist yourself?

Ms. MITCHELL. Yes.

Mr. MOODY. Why was HCFA so adamantly opposed to this very proposal last year when you testified before this subcommittee?

Ms. MITCHELL. Well, they had gone on record as being against physician DRGs, and this was an extension of DRG payment.

Mr. MOODY. You heard earlier some of the people on the panel suggest that the incentive structure would be quite different if it was what he referred to as the RAP, Inc. approach as opposed to using the hospital as the conduit. Do you have any comments on that? Just walk through how you see the incentive structure, cost containment and health quality adequacy differing between those two.

Ms. MITCHELL. I think that the incentives are considerably weaker if the payment is made to RAP, Inc. rather than to the hospital.

Mr. MOODY. The incentives for which of the two goals, health care adequacy or cost containment?

Ms. MITCHELL. Cost containment, because the services are being provided in the hospital, and the hospital is already bearing the technical costs of those x rays and lab tests, and where there are hospital-employed CRNAs, the anesthesia as well. So that a payment made to RAP, Inc., would not allow the efficiencies that paying the hospital would.

Mr. MOODY. So by bundling it together as a hospital item the incentives to eliminate marginal x rays, et cetera, would be—those incentives would be there, as opposed to the RAP, Inc., where the——

Ms. MITCHELL. I think they would be more diluted. They are stronger when you pay the hospital because you are building on the prospective payment system already in place under Medicare.

Mr. MOODY. We have 10 minutes left to vote. Why do we not take a 5 minute recess? Do you mind waiting? There may be another question for you?

Ms. MITCHELL. No, not at all.

Mr. MOODY. Thank you.

[Recess.]

Mr. MOODY. Let us resume. Thank you for being patient while we vote.

I gather from Mr. Levin's questions that you have taken a position. You did not start, I assume, with one, but you now have one as a result of your study; is that correct?

Ms. MITCHELL. The study that I have been working on most recently, looking at DRG-based payment for RAP physicians is the

extension of work that has gone on for years on different ways of packaging physician services, and this just happens to be one of them.

Mr. MOODY. Did you have a contract or a grant to study specifically RAP, or is this just your position on RAP or your knowledge of RAP has grown out of your general research?

Ms. MITCHELL. I originally had a grant from HCFA to study the feasibility of physician DRGs, to include all physician inpatient services into a DRG. That grant was the direct result of Congress' having asked HHS to look at that. And we have done a lot of work on that area, and I have testified on that. And it was an extension of that existing physician DRG work that I decided to look at a more narrow definition of physician inpatient services that might be considered more feasible in the short run than an all-inclusive physician DRG approach.

Mr. MOODY. Are there significant institutional or technical reasons why these three specialties make sense, or make more sense as a possible way to go, rather than, let us say, surgeons or other physicians in the hospital?

Ms. MITCHELL. I think that the most important reason, as others have pointed out, is that patients do not shop for these physician services based on price or willingness to accept assignment.

Mr. MOODY. Whereas they do shop for surgeons?

Ms. MITCHELL. We hope that they shop. That is the idea behind the Medicare participating physician program, that patients do shop based on price and willingness to take assignment.

Mr. MOODY. I guess I am going to try to ask what Congressman Pickle asked you in a slightly different way. You say that this system, if applied, would probably help rural hospitals. Do you want to elaborate a little bit on that?

Ms. MITCHELL. Ideally what I would have done would have been to simulate a RAP DRG proposal that had been put forth, either by Congress or by the administration. There was no such proposal to simulate, so what I did instead was to simulate what would happen using DRG cost weights and making adjustments for geographic cost of practice differences, but with no other adjustments, such as outlier payments, and indirect medical education adjustment, or an urban-rural differential.

I suspect that if someone had done similar work to mine prior to the implementation of PPS, they also would have found that rural hospitals are winners. So that it is partly an artifact of what I did. And I suggest that if this was something that people were concerned about, they could obviously change it through the actual design of a RAP program to have an urban-rural differential, if that was something that you were concerned about.

Mr. MOODY. And then that advantage might evaporate.

Ms. MITCHELL. Yes, absolutely.

Mr. MOODY. Do you think there would be an impact on quality? We have been trying—that is such a hard question to answer, but we have been trying to ask it. You mentioned that rural hospitals, for example, do not use—or frequently do not have resident anesthesiologists.

Ms. MITCHELL. They are less likely.

Mr. MOODY. And they use—what was the term you used?

Ms. MITCHELL. CRNAs, certified registered nurse anesthetists.

Mr. MOODY. Were you implying that there is no appreciable quality difference between the services provided by that person and an anesthesiologist?

Ms. MITCHELL. There is no question but that anesthesiologists have far more training than do CRNAs, and no one would dispute that.

Mr. MOODY. Right.

Ms. MITCHELL. There have been quality studies comparing the two provider groups that have been done, and they have failed to find differences in outcomes. But it is important to keep in mind that CRNAs are often, if not usually, supervised by anesthesiologists. I would never suggest that CRNAs be substituted for anesthesiologists in toto at all. The point is, what is the most appropriate mix of CRNAs and anesthesiologists, and whether there is a way to encourage hospitals and physicians to use those two provider groups in their most optimal mix.

Mr. MOODY. And you say in a rural hospital they may not be optimal either because they may not have an anesthesiologist.

Ms. MITCHELL. Right.

Mr. MOODY. But if they had the same DRG system, then they would obviously benefit financially from that arrangement.

Ms. MITCHELL. To the extent that CRNAs are less expensive than anesthesiologists, they would. It is possible that anesthesiologists might be attracted to these areas if the payment rates were higher.

Mr. MOODY. I understand from your testimony that gains and losses would be relatively small. I guess I have a note here that says, $10 to $15 per case. In comparison to hospital payments in excess of $3,000 per case, I guess we are looking at gains or losses, winners or losers, as you said, resulting in a very, very small percentage of the total bill. Is that a fair statement?

Ms. MITCHELL. Yes, that is certainly true; very small.

Mr. MOODY. Any questions of anyone else.

[No response.]

Mr. MOODY. This has been very helpful. Let me just quickly ask, did you do an econometric study? Can you just give me an idea of the design of your study?

Ms. MITCHELL. We had all Medicare admissions from four States in 1984. And we took those admissions and looked at them at the hospital level to examine whether they would have made or lost money on every individual case, and then summed across all cases to look at what the total gain or loss would have been at the hospital level.

So it was a simulation that did not take into any behavioral change, which is very important to keep in mind. These gains and losses are what one would expect if no hospitals or physicians changed their behavior. But of course, we are expecting and hoping that they will change their behavior.

Mr. MOODY. That is the whole point of the DRG system, is to induce changes in behavior.

Ms. MITCHELL. Yes, absolutely. But because I did not include any dimensions other than DRG and geographic cost of living into the analyses. We did econometric analysis to look at, for example, whether teaching hospitals would continue to lose even after one

took into account their use of CRNAs, their disproportionate number of PPS outliers, the disproportionate number of transfer patients that they receive, et cetera. And yes, they would still lose money even after taking into account those different factors.

Mr. MOODY. Did you assume a solvency constraint?

Ms. MITCHELL. Yes, we assumed that it would be budget neutral. And the reason that you then have over half of the hospitals winners, is because they tend to be small hospitals. It was budget neutral at the admission level, not at the hospital level.

Mr. MOODY. But in fact if we had a RAP DRG system, we would presumably be spending less total money, and that would be a budget saving, and therefore, your numbers would need to be rerun on that assumption. Am I right?

Ms. MITCHELL. I would not think that would be the case in the first year necessarily.

Mr. MOODY. No, not necessarily. But over a long haul——

Ms. MITCHELL. But in the long run, yes, the only way to achieve cost savings would be recalibration in the future, which would be justified based on improved efficiency in the system.

Mr. MOODY. Since you took a solvency constraint as the anchor point of your study, you did not then go out and assume any particular fees associated with any of the three skills, did you?

Ms. MITCHELL. No, the estimated payment rates were based on average allowed charges.

Mr. MOODY. Okay, thanks. Mr. Donnelly, any questions?

Mr. DONNELLY. No.

Mr. MOODY. Okay, thanks very much. It was very interesting testimony.

All right, I guess we have our final panel. We have the representative of the American Society of Anesthesiology, Dr. Howard Zauder. We have the representative of the American College of Radiology, Joseph Marasco, Jr., M.D. And finally, but certainly not least, we have the representative of the College of American Pathologists, Dr. Raymond Zastrow.

Let me exercise the prerogative of my new-found powers here as chairman pro tempore to welcome Dr. Zastrow who is from my own community, Milwaukee. Dr. Zastrow is director of the Department of Pathology at St. Michael's Hospital in Milwaukee, WI.

We are certainly happy to have all three of you. Is there any particular order you would like to go in. Any order you wish, thank you.

STATEMENT OF RAYMOND C. ZASTROW, M.D., MEMBER, BOARD OF GOVERNORS, AND CHAIRMAN, COUNCIL ON GOVERNMENT AND PROFESSIONAL AFFAIRS, COLLEGE OF AMERICAN PATHOLOGISTS

Dr. ZASTROW. Mr. Chairman, members of the Subcommittee on Health, I am Raymond Zastrow, I am a board certified pathologist practicing at St. Michael Hospital, a 425-bed hospital in Milwaukee, WI. I am chairman of the Council on Government and Professional Affairs of the College of American Pathologists, and a member of its board of governors.

The college believes that changes in the part B system for physician services require careful analysis because of the potential impact on quality, availability and the cost of physician services to beneficiaries. While there are problems with the current system, we believe that precipitous change is not warranted because of the potential for unanticipated adverse effects on patient care.

My full statement outlines for you the current Medicare payment methodology for pathology part B services, and the significant changes brought about in our practice during the past 5 years. These problems illustrate the inequities and arbitrary nature of the current system. The college believes the DRG-based payment system will exacerbate current problems and create new problems.

Several options for implementation of the RAP DRGs have been discussed by administration officials here and in public forums. Our reason for opposition to the RAP DRGs in any form are, one, inappropriate financial incentives to reduce pathology services would be added to a hospital DRG system which already provides incentives to reduce care. RAP DRGs would be an unnecessary disruption and create significant potential for adverse effects on quality.

Two, Medicare part B data on pathology services is inaccurate and unsuitable for construction of RAP DRGs.

Three, the DRG averaging concept is inappropriate for pathology services and will produce arbitrary underpayments and overpayments to pathologists. Pathologists do not initiate utilization of their services, and would not be able to shift resources to adjust to average per case payment.

RAP DRGs have minimal potential for budget savings, and hold no potential for decrease in utilization of pathology services. We know of no evidence that pathology services are overutilized.

Five, effective physician payment reform must consider the interrelationship of services of all physicians. Radical changes in the payment methodology for a subset of specialties is inappropriate.

Mandatory assignment has been suggested as an accompaniment to RAP DRGs. Most Medicare claims for pathology services are assigned. The Medicare participation rate of pathologists is among the highest. We believe the major reason for nonassignment is inequitably low Medicare payment levels in some areas, as described in my full statement. Mandatory assignment is not necessary to protect Medicare beneficiaries and would not be an equitable approach for pathology services.

The college is not calling for continuation of the current system, however. We recommend a four-step approach to Medicare's part B reform. One, allow Medicare reimbursement policy changes made by Congress and the Department of Health and Human Services over the past 5 years, which have greatly affected pathology services to become fully implemented and their effects know.

Two, consider the results of the Harvard University relative value study. Pathology and 29 other specialties are involved in this effort to establish a system of resource-based relative values among physician services. Results of the Harvard study may be useful in identifying the nature and magnitude of current inequities in the Medicare Reimbursement System.

Three, consider recommendations of the Physician Payment Review Commission created by Congress. The Commission recently endorsed the use of a fee schedule for Medicare payment for physician services. The Commission indicated it will make more definitive recommendations in the future. Those recommendations should be considered and evaluated before embarking on any physician payment reform methodology.

Four, reform the reimbursement system across all specialties, rather than considering drastic change in the current methodology for only selected specialties. Effective reform must consider the interrelationships of all physician services.

In conclusion, the college is not opposed to equitable reform of the Medicare part B physician payment system. We are, however, opposed to arbitrary selection of a subset of physicians for inclusion in a payment system for which there is no experience and which holds potential for significant disruption in quality medical care.

The college supports reform which involves correction of current inequities in the part B system, and which reforms payment methodology across all physicians in a reasonable manner.

The College of American Pathologists appreciates the opportunity of sharing with the subcommittee these views on physician payment reform. I would be happy to respond to questions.

[The prepared statement follows:]

Statement of the
College of American Pathologists
to the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

May 13, 1987

Mr. Chairman and Members of the Subcommittee on Health. My name is Raymond Zastrow, MD. I am a board certified pathologist practicing at St. Michael Hospital, a 425-bed hospital in Milwaukee, Wisconsin, where I am the Director of the Department of Pathology. I am the Chairman of the Council on Government and Professional Affairs of the College of American Pathologists, a national medical specialty society representing more than 10,000 pathologists who practice medicine in community and teaching hospitals and in independent laboratory settings.

Today I am pleased to present CAP's views on the proposal to include pathology in a DRG payment system.

The College believes that changes in the Part B system for physician services require careful analysis because of the potential adverse impact on quality, availability, and cost of physician services to beneficiaries. Fee-for-service payment has, so far, assured Medicare beneficiary access to high quality medical care. It should not be abandoned in favor of other forms of payment which have not been adequately investigated. While there are problems with the current system, we believe that precipitous change is not warranted.

Pathology Services to Patients

Our concerns will be better understood if I first describe what a pathologist does and then describe how pathology services are currently paid under Medicare. Pathology is generally divided into two major categories: clinical pathology and anatomic pathology. The pathologist specializes in diagnosing diseases found in all areas of the body. Through examination of body tissues, fluids, or other specimens removed from the body, the pathologist determines whether disease exists, the nature of the disease, and what changes the disease has produced in the patient. The pathologist reports his or her findings to the patient's personal physician and assists that physician in determining the correct diagnosis and best course of treatment.

Often from the patient's perspective, the pathologist's work is not visible. Such is the case for a surgical patient who is on the operating table and anesthetized when the pathologist examines tissue suspected of being cancerous -- and confirms whether or not a malignancy is present. Similarly, the patient may be unaware that it is the pathologist who consults with the attending physician to determine the implications of unexpected laboratory test results or that it is the pathologist who matches the tissue for a transplantation procedure.

Pathologists practice medicine to find answers to bring together, on a daily basis, the scientific medical knowledge about disease and the patient's presentation of the disease. In this role, the pathologist most often will communicate his findings to the patient's personal physician. However, the pathologist's primary responsibility is to the patient -- to ensure to the degree possible that disease is accurately diagnosed when it is present.

The Current Medicare Payment System

Medicare regulations divide pathology services into two categories: physician services to an individual patient (e.g.,

surgical pathology, cytopathology, hematology, blood banking services) which are paid on a fee-for-service basis under Part B; and services which benefit all patients (e.g., quality control, infection control, technology evaluation and implementation, morbidity and mortality analysis, and laboratory administration) which are paid under Part A through the hospital DRG rate. Significant amounts of the pathologists' time and effort are involved in the provision of care to individual patients and are therefore billed on a fee-for-service basis to Part B. Therefore, proposals for change in the method of paying for Part B physician services are critically important to our members and the beneficiaries they serve.

The provider-based physician regulation which implemented Section 108 of TEFRA redefined Part A and Part B pathology services and eliminated hospital combined billing for physician Part B services. The regulation requires that Part B services be separately identified and billed to Part B. Today, like other physicians, most of our members are not paid by the hospital for Part B services; instead they directly bill on a fee-for-service basis for services to Medicare beneficiaries as well as to other patients.

TEFRA regulatory changes in conjunction with the 1984-86 physician fee freeze had a severe impact on pathology. Many pathologists received Part B payments based on prior combined-billing arrangements that did not reflect historical charging practices of pathologists or the resource costs associated with the service. Payment for Part B services was frozen at levels which were often below what any objective analysis would deem reasonable. These problems significantly distorted the Part B database for pathology services.

Pathology services which are of general benefit to all hospital patients (e.g., quality control) are paid under Part A through the hospital. Prior to the enactment of the prospective payment system in 1983, these services were paid to the hospital on a reasonable cost basis. Currently, payment for these services is included in the prospectively determined hospital DRG rate. The financial incentives of the hospital prospective payment system have resulted in significant hospital pressures to reduce Part A payments to pathologists. Because Medicare rules do not require the hospital to make Part A payments to pathologists, some hospitals have refused to pay the pathologist for Part A services, even though the DRG rate includes payment for the service.

The problems I have outlined illustrate the inequities and arbitrary nature of the current system. The College believes a DRG-based payment system will not correct the inequities of the current system. Instead, it will exacerbate current problems and create new problems.

DRG-Based Payment for RAPs

Against this background, I would like to discuss the proposal to pay for pathology Part B services on the basis of diagnosis related groups (DRGs).

The College of American Pathologists shares the concerns of Congress with the growth in federal payments for medical care and with the increase in out-of-pocket costs of the Medicare beneficiary. Pathologists understand that payment for physician services needs to be reevaluated and considered in the context of limited fiscal resources available to the federal government and beneficiary access to services.

Physician payment changes that single out radiologists, anesthesiologists, and pathologists for special treatment are not, in our opinion, justified. Pathology services should be

considered as part of the comprehensive reform of physician payment that is under way. Piecemeal radical change for only pathology services and other selected specialties would be unnecessarily disruptive and could adversely affect patient care.

The Administration's FY 1988 budget proposes the use of MD-DRGs to pay for the services of radiologists, anesthesiologists, and pathologists (RAPs) to Medicare inpatients. The proposal is known as MD-DRGs for RAPs.

The MD-DRG proposal is an abrupt change in payment methods. The new system would include the services of pathologists and other selected specialties under a DRG payment system. Medicare would pay an average predetermined amount for RAP services for each Medicare hospital discharge according to the patient's hospital DRG.

Although, to the best of our knowledge, the Administration's legislative proposal has not been finalized, several options for implementation have been discussed by Administration representatives in a number of public forums. Two basic options have been described:

1. Include payment for pathologists and other hospital-based physician services in the hospital Part A DRG rate with assignment mandatory.

2. Pay the MD-DRG amount to a medical staff entity comprised of radiologists, anesthesiologists and pathologists (RAP, Inc.). Assignment would not be mandatory, but there would be limitations on balance billing.

Zach of these options has significant potential for adversely affecting the provision of pathology services and the quality of care available to beneficiaries. Proponents claim that DRG payment would create incentives for greater efficiency. We believe a DRG system is more likely to lead to reductions in needed services and would compromise the individual physician's ability to provide quality care. We are opposed to DRG payment; none of the options for implementation is appropriate.

Reasons for Opposition to DRGs

The use of Diagnosis Related Groups (DRGs) as the basis of payment for all physician services has raised serious questions concerning the feasibility of this approach. We believe that DRGs are also inappropriate for pathology services. I would like to focus on some of the reasons for our opposition and then discuss our alternative recommendations for development of a rational system for paying for pathology Part B services.

1. Financial Incentives. Any MD-DRG payment system will introduce inappropriate financial incentives into the provision of direct patient care services to patients. Fee-for-service for physician services provided to hospital inpatients is an important countervailing force to the incentives now in place under the hospital DRG system. There is already much concern that the DRG prospective payment system for hospital services has great potential for suboptimal care. It is a mistake to extend the DRG system to the direct patient care activities of hospital-based physicians.

   If the hospital were paid the DRG amount, hospital-based physicians and attending physicians would be under pressure from the hospital to reduce Part B services to Medicare inpatients. Hospitals could earn a profit or lose money on Part B services. Hospital efforts to deal with these new incentives in the arena

of physician direct patient care activities holds great potential for reducing quality. Hospital economic incentives should not be allowed to determine when, whether, or to what extent pathology services are provided to individual Medicare patients.

If RAP, Inc., were paid the MD-DRG amount additional concerns become apparent. The financial incentive to reduce services would shift from the hospital to an entirely new artificial entity, an entity for which there is no practical experience as a guide to assess probable impact. The three involved specialties would presumably negotiate payment among themselves, but without the ability to control utilization of their services. We see no benefit to a system which forces physicians to trade off patient care resources among specialties.

2. Part B Data for Pathology Services. In the past few years, Medicare requirements for billing and reporting pathology services have undergone substantial and repeated changes. These changes have been implemented during the period when other general Part B program changes have occurred, such as Medicare carrier conversion to a common procedural coding system, imposition of a freeze on physicians' actual charges, and inclusion of some pathologist's services in the hospital DRG payment.

The result is a Medicare Part B database for pathology services which is in a transitional phase and is inherently inaccurate. This data should not be used as the basis for yet another, and more radical, change in Medicare reimbursement policy for pathology services, such as a MD-DRG.

The MD-DRG payment amount would likely be based on FY1984 or 1985 Part B allowed amounts. HCFA has publicly acknowledged that FY1984 data for pathology services are incomplete and inaccurate because of TEFRA billing changes and the recent conversion to a new physician coding system (HCPCS). FY1985 and 1986 data will not be much better because the billing system will not reflect all of these changes. There is continuing variation in Medicare carrier implementation of HCFA instructions regarding reimbursement for pathology Part B services.

The physician fee freeze has compounded the problem of inaccurate and incomplete Part B data. Medicare Part B customary charges for pathology services prior to May 1, 1986, were often developed based on combined billing arrangements that predated the implementation of TEFRA. These compensation-related customary charges (CCRCs) limited Medicare payment to unreasonably low amounts because they were not based on historical charging practices of pathologists or on procedural resource costs. Pathologists' low CRCCs were frozen from July 1, 1984, until May 1, 1986, when Congress eliminated the use of CRCCs in determining payment for pathologists who direct bill Medicare.

Medicare prevailing charge screens for pathology services are also affected by the lack of accurate historical charge data for pathology services. Many carriers used "gap filling" techniques to establish pathology prevailings during 1983 through 1986. In the normal course of events, gap filling applies to only a small number of the total services an individual physician provides over a very limited period of time.

In the case of pathologists, gap filling was used by some carriers to establish prevailings for most of the services pathologists performed. Moreover, the physician fee freeze kept the "gap filled" prevailings in place until May 1, 1986.

3. The DRG as a Basis for Payment. To our knowledge, no definitive studies exist that demonstrate the DRG would be adequate for predicting expected pathology resource requirements. Given the Part B data problems I have described, it is unlikely that a study using historical Part B data could be relied upon to determine the feasibility of using the DRG as the unit of payment for pathology services.

   The DRG averaging concept is unlikely to work well when applied to pathology services. Patients classified within the same DRG will require different pathology patient care services, depending on the stage of diagnosis and the treatment plan. Pathology services are provided to patients in association with surgical and other services which are not initiated by the pathologist. Therefore, the pathologist has little opportunity to shift resources between patients in order to adjust to a DRG averaging concept. The payment of an average DRG amount is likely to result in arbitrary underpayments and overpayments to individual patholcgists.

4. RAP-DRG Budget Savings. Medicare Part B payment for inpatient RAP services is only 10% of total physician payments. Medicare Part B approved amounts for pathology services are less than 1% of total Medicare approved amounts for physician services, according to a 1986 Congressional Budget Office report on physician reimbursement. In our opinion, the potential for budget savings is minimal.

   We know of no studies which indicate that pathology Part B services are inappropriately ordered or over-utilized. Pathology services are provided in association with surgical services or diagnostic procedures which are not initiated by the pathologist. Therefore, MD-DRGs for pathologists have no realistic potential for encouraging more effective utilization of pathology services.

5. Pathologists and Medicare Assignment. It has been suggested that DRG payment for hospital-based physician services could be implemented with mandatory assignment or with limits on balance billing.

   Many pathologists are Medicare participating physicians and accept assignment for all Medicare services. A recent study funded by the Health Care Financing Administration (HCFA) shows that our specialty has a very high participation rate - approximately 50 percent of pathologists have signed participating physician agreements. Many pathologists who have not signed participation agreements do accept assignment for Medicare services. According to the HCFA-funded study, 17% of nonparticipating pathologists accept Medicare assignment on 100% of their cases. An additional 41% of nonparticipating pathologists accept assignment on some of their Medicare claims. Thus the assignment rate for pathology services is much higher than the participation rate. When more recent data on assignment rates by physician specialty are available, we believe they will continue to show that pathologist assignment rates are high.

It is not necessary to mandate assignment or establish arbitrary limits on pathologists' charges.

6. Quality and Access. Some proponents of MD-DRGs for provider-based physicians claim that beneficiary access to quality services will not be adversely affected. No studies exist which demonstrate the impact on quality and access of an MD-DRG payment system for pathology services.

   The financial incentive of an MD-DRG payment system is to reduce services because the payment amount would remain the same regardless of the services actually provided. If the hospital is paid, the hospital would be imposed into the physician's medical decision-making process concerning the diagnosis and treatment of individual patients. It is our opinion that hospital-physician relationships would be disrupted. If RAP, Inc., were paid, physician relationships with one another would be disrupted. Disruption of these relationships should be of concern to federal policy-makers because it will affect the ability of all physicians to provide high quality care.

7. Future Delivery of Pathology Services. Of particular concern to the College is the effect of radical change on the future supply of pathologists. Data from the National Residency Matching Program for 1986 show declining interest in pathology by medical school graduates. The percentage of pathology residency positions filled has declined from 67% in 1983 to 58% in 1986. In contrast, 86% of all physician residency training positions were filled in 1986. In 1983, 326 pathology residency positions were filled. Only 276 positions were filled in 1986.

   This decline began and continued during the disruption caused by TEFRA and the implementation of hospital DRGs in 1983.

   A period of stability is now required to allow our specialty to adjust. MD-DRGs for RAPs will mean further disruption and raises serious questions about the available supply of pathologists for the future.

Alternative Recommendations for Physician Payment Reform

The College recognizes that the Medicare payment system will be changed and supports appropriate efforts to improve Medicare payment methodology for physician services. In my remarks I have described problems with current Medicare data on pathology services that make the data unsuitable as a basis for construction of MD-DRGs or any other radical change in payment methodology. The College is not calling for continuation of the current system, however. Instead, the College recommends a four-step approach to Medicare reform of payment for physician Part B services:

1. **Allow Medicare reimbursement policy changes made by Congress and the Department of Health and Human Services over the last 5 years, which have greatly affected pathology services, to be fully implemented and their affects known.**

   Only when pathologists and Medicare carriers have adjusted to recent changes will the Medicare database on pathology services move from a transitional to a stable mode. In the interests of equity and accuracy, this stabilization should be allowed to occur.

2. **Consider the results of the Harvard University Relative Value Study.**

   Only last year, Congress directed the Secretary of HHS to develop a RVS and submit recommendations for its application. Pathologists and 29 other specialties are involved in this effort to establish a system of relative values among physician services. Results of the Harvard study may be useful in identifying the nature and magnitude of current inequities in the Medicare fee-for-service system.

3. **Consider the recommendations of the Physician Payment Review Commission created by Congress.**

   The Physician Payment Review Commission recently endorsed use of a fee schedule for Medicare payment for physician services. The Commission indicated that it will make more definitive recommendations in the future. Those recommendations should be considered and evaluated before embarking on any physician payment reform methodology.

4. **Reform the fee-for-service system across all specialties rather than considering drastic change in the current methodology for only selected specialties. Effective reform must consider the interrelationships of all physician services.**

   The present system has afforded Medicare beneficiaries access to very high quality medical care because, with all of its problems, the fee-for-service system does provide strong physician incentives for excellence in diagnosis and treatment. Changing that system of incentives is an undertaking that has the potential for unintended adverse impact on Medicare beneficiaries. Changing the system precipitously and without first establishing an adequate and equitable database is even more risky.

   It is totally inappropriate to establish negative incentives for diagnosis and treatment among a subset of specialist physicians whose services affect the ability of other physicians to provide high quality medical care.

Conclusion

The College is not opposed to equitable reform of the Medicare Part B physician payment system. We are opposed to arbitrary selection of a subset of physicians for inclusion in a payment methodology for which there is no experience, unacceptable data, and which holds potential for significant disruption in quality medical care. The College supports a reform methodology which involves correction of current inequities in the Part B system and which reforms payment methodology across all physicians in a reasonable manner.

The College of American Pathologists appreciates the opportunity of sharing with the Subcommittee its views on Medicare physician payment reform. I will be pleased to respond to questions.

Mr. MOODY. Thank you very much. There probably will be some commonality. Maybe we should go ahead with the other two gentlemen and then we will ask questions at that point.

All right, any particular order of the two of you.

STATEMENT OF HOWARD L. ZAUDER, M.D., PRESIDENT, AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Dr. ZAUDER. Thank you. I am Howard Zauder, current president of the American Society of Anesthesiologists. We appreciate the opportunity, Mr. Chairman, to appear before the subcommittee today and have already submitted our formal statement for the record, and would be very happy to amplify on it at the conclusion of these remarks.

The American Society of Anesthesiologists, like our colleagues, opposes the administration's proposal to create a DRG-based reimbursement method for services by our three specialties to Medicare inpatients. In terms of our practice, we believe that such a system will intrinsically interfere with the existing direct relationship that we have with our patients.

The American Society of Anesthesiologists represents virtually all practicing anesthesiologists in the United States; 80 percent of our members are, and have been since 1949, prior to both TEFRA and the Medicare legislation in independent fee for service private practice.

The services for which we charge a fee involve direct interaction with the patient, and include the preoperative evaluation, selection of an anesthetic plan that is appropriate for the specific patient and their pathology, hands-on care and protection of the patient during the operative period when their basic physiologic systems are of necessity suppressed, and then the postoperative restoration of these systems to normal without, we hope, undue complications.

In recent years since the Supreme Court ruled on the Hyde case some 3 years ago, we find that approximately a third of our members have entered into written contractual arrangements with hospitals. In 75 percent of the cases, these are exclusive contractual arrangements, and some 20 percent of these limit reimbursement.

The relative value guide that the society promulgated several decades ago is utilized as the basis for determining a fee structure. But in 20 percent of the people who have exclusive contracts, this conversion factor is limited by the institution.

We find an increasing number of such contracts and anticipate that there is a competitive situation coming into play that is not the type that we usually think of in terms of competition among anesthesiologists on a hospital staff, or between groups of anesthesiologists. But it is indeed competition that is being imposed upon anesthesiologists by hospitals which are struggling for survival and are attempting to attract patients. So we believe that there is a competitive force entering the marketplace that will determine anesthesiologists' fees.

We believe that the creation of a RAP DRGs, if the payment be provided to the hospital or to RAPs, Inc., will interpose between the profession and the patient, a gatekeeper which will interfere with the patient-specific manner in which we provide care, and the

patient-specific manner in which we are reimbursed for that care. In the latter respect, averaging by DRG category of payment for our services will lead inevitably to distortions in the level of payment in individual cases.

Our preliminary analysis tells us that there are wide variations in anesthesia complexity and in anesthesia time, the two determinants of the care that we provide an individual patient, within many of the hospital DRGs that are already in place. For example, if one examines DRG 110, it includes anesthesia for procedures that vary widely in difficulty from surgery on vessels in the periphery, to surgery for resection of an aortic aneurysm. Obviously, very different procedures of very great variability and difficulty, complexity, skill required.

Nevertheless, if these were lumped and averaged, there would invariably be overpayment, significant overpayment we think for some procedures, with underpayment for but a very small number. And we do not believe on the basis of some preliminary information, that this would balance out.

We have in our formal statement provided you with examples of lack of homogeneity in anesthesia time for given surgical procedures in the same institutions. We believe that there is, therefore, little correlation between the intensity and the complexity of the service rendered under particular DRGs, and we believe that there is great variability in services rendered by the three specialties under a particular hospital DRG.

Proponents of the DRGs claim that they will result in greater efficiencies in medical care. The fact is, however, the anesthesiologists have virtually no opportunity to order unnecessary or costly additional services. The only way to decrease the utilization of anesthesia services is to decrease the utilization or the incidence of surgery in this country. There may be unnecessary surgery, but there is certainly no unnecessary anesthesia. We do not make that decision.

It has been suggested that greater efficiency can be achieved by using more nurse anesthetists in the delivery of anesthesia care. It is true that there may be 1,200 to 1,500 rural hospitals in this country that have only nurse anesthetists. I would point out, Mr. Chairman, that these hospitals only provide 8 percent of the surgical care in this country. And the surgical procedures that are undertaken in these institutions are certainly not of very great magnitude.

The current Medicare rules already provide incentives for the use of the anesthesia care team approach, pursuant to which an anesthesiologist may simultaneously direct more than one nurse anesthetist. Be that as it may, we strongly believe that in light of the complexities and dangers inherent in anesthesia care, encouragement of the use of nurse anesthetists without specific medical direction by an anesthesiologist would be a major disservice to Medicare patients.

We do not believe that you are looking at interchangeable personnel, and we certainly do not believe that the choice of anesthesiologists or certified registered nurse anesthetists is one that can be made by a hospital or a hospital administrator. We believe very

strongly and very firmly that this is a medical decision, and not an administrative decision.

It is clear from our formal statement that we favor the use of a relative value guide methodology. It takes direct account of anesthesia complexity and time in an individual case, it allows for differences of complexity for different procedures, and it is patient specific. It is also responsive to changes in medical technology allowing for an automatic reduction in cost when technological advances simplify the necessary anesthesia care.

In our formal statement we illustrate this point by showing how, in the case of pacemaker insertion in recent years, anesthesia complexity and time units have declined from somewhere between 30 and 34, to approximately 12.

Medicare has for years reimbursed anesthesiologists on the basis of the relative value system, and in general the system works, from our perspective at least, well for both us and for the Government. As noted in our formal statement, we believe that improvements can be made.

The use of several different guides by Medicare carriers makes absolutely no sense from the medical point of view. A resection of a lung is the same in Syracuse, NY, as it is in Milwaukee, in Tucson, or in California. And so the utilization of 40 or 50 different relative value guides—and you heard from the General Accounting Office that there is great variability in the base units—makes absolutely no sense.

In addition, the low authorized rate of payments by carriers in several States simply makes no sense in terms of a national fee schedule of some type. And we are led to believe that the degree of acceptance of assignment, particularly in Appalachia, the Midwest, and parts of rural Kansas, are as low as they are because of the unrealistic rate of reimbursement. And we do indeed know that some of our people in Kansas lose 73 cents on a dollar for every patient they anesthetize if they employ a nurse anesthetist and accept assignment. And that is one of the explanations for the low rate of acceptance.

As a matter of Medicare reimbursement policy, the ASA favors continued support for the work of the Physician Payment Review Commission. They have recommended development of fee schedules for paying for physician services under Medicare, and we have publicly supported the concept of development of a uniform relative value guide-based fee schedule.

We believe that this is a highly workable concept. It has been in place for a long time, and all one has to do is manipulate the conversion factor to arrive at an appropriate fee schedule.

In terms of the current budget issue, we certainly recognize that there is difficulty, and we recommend that any part B budget savings be achieved by applying reimbursement reforms to all physicians, and not just to a few.

We are certainly aware of the fact that the subcommittee is concerned with the issue of balance billing to patients. We think that once again this is due to variation and to the conflicting relative value guides that are used by carriers. We would point out that under current law there are significant restraints already in place

with reference to balance billing, certainly under the inherent reasonableness.

Congress may also wish to consider in this respect an income related assignment system. For our part, the leadership of our society is embarking upon a program to encourage our members to voluntarily increase their assignment rate. And we believe that we can do this, one, by further educating our members, and more importantly, by educating the patient and attending physicians.

We talk about lack of choice. I would point out that the three of us are not the only ones who may be referred patients. It applies to a host of physicians who work in hospitals. If one suddenly has chest pain and is taken to Capitol Hill Hospital just up the street, you will have no choice of the invasive cardiologist who catheterizes you. You will take whoever is there, and you are not going to ask him if he accepts assignment or not. That is something that you will discuss after the fact.

Thank you, Mr. Chairman.

[The prepared statement follows:]

FOR RELEASE
1:30 P.M., May 13, 1987

STATEMENT OF
HOWARD L. ZAUDER, M.D., PRESIDENT
AMERICAN SOCIETY OF ANESTHESIOLOGISTS
before the
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS & MEANS
U.S. HOUSE OF REPRESENTATIVES
May 13, 1987

Mr. Chairman and members of the Subcommittee. I am Howard L. Zauder, M.D. I am a practicing anesthesiologist and Professor and Chairman of the Department of Anesthesiology at the Health Sciences Center, State University of New York, at Syracuse, New York. I am the current President of the American Society of Anesthesiologists (ASA), a national medical society with a membership of 22,000 physicians or other scientists engaged or professionally involved in the medical practice of anesthesiology.

The Society welcomes the opportunity to offer its views on the proposal to implement a DRG-based method for reimbursement of services by anesthesiologists and other medical specialists to Medicare inpatients.

I. Opposition to DRG's for RAPs

Last year, before this Subcommittee, we expressed serious objections to the general notion of a DRG methodology for payment of physician services. Since that time, the Administration has included the so called DRG-for-RAPs proposal in its FY1988 budget and we, in concert with other medical societies, have sought co-sponsors for House Concurrent Resolution 30, which in significant part opposes such a proposal at this time.

A. Interference with patient relationship. As the Subcommittee is already aware, we oppose the DRG proposal for a variety of reasons. First, and perhaps most important, we believe that a physician DRG system will, in practical application, severely interfere with our direct relationship with patients. Contrary to the myth currently in vogue among Administration DRG proponents, over 80% of anesthesiologists are now, and for many years prior to the inception of Medicare have been, physicians who provide care on a fee-for-service basis to their individual patients. In whatever form implemented, a DRG system will place a third-party -- a hospital or some other person or entity -- between the anesthesiologist and his or her patient. Even if we lay aside our grave quality-of-care concerns about such a system, we are deeply disturbed by the concept that we would be providing our service, not to the patient, but to the hospital or to some other entity.

In this connection, I must express the outrage of anesthesiologists at the recently published characterization of our medical services as not involving patient advocacy and as being "more machine-oriented, where the service simply doesn't require any . . . or very limited physician-patient interaction."

I would ask, perhaps rhetorically, whether patient advocacy is not involved (1) pre-operatively in the selection, from among an array of potentially lethal anesthetic agents, of the appropriate anesthesia plan for an individual patient, (2) during the operation, in the "hands on" maintenance of the patient in a carefully controlled anesthetized state, at a medically- determined level between consciousness and death, while the surgeon or obstetrician performs the procedure, and (3) post-operatively, in restoring the patient's respiratory and cardiovascular systems to normal, without undue complication.

Of course sophisticated and complex monitoring equipment helps us in that process, but all the equipment in the world does not substitute for the judgment of the anesthesiologist in interpreting the monitors and making certain nothing goes wrong, or if it does go wrong, making the necessary corrections to save the patient's life. If patient-physician interaction is not involved in literally breathing for a patient, when he cannot do that for himself, I do not know what is.

B. "Averaging" of services. Our opposition to the DRG proposal also stems from our deep concern that hospital DRG's do not describe or measure the anesthesia services provided to patients falling within those DRG's. What physician DRG's will inevitably represent is a reimbursement system that seeks to "average" medical care within DRG categories that simply were not constructed to account for that care and which, in any given case, will bear no necessary relationship to the services actually rendered to a particular patient by the anesthesiologist or, as far as we are aware, by the radiologist, pathologist or for that matter by the surgeon.

From our own informal surveys, we are aware that there are significant variations just in the time devoted by anesthesiologists to providing anesthesia in connection with ten common surgical procedures. For example, ASA members were asked to report, for a six-month period in 1984, the shortest, longest and average time required to perform the ten procedures. The results reveal wide differences in average time required for almost all of the surgical procedures, but more significantly, they demonstrated a very limited grouping around a common mean.

Let me give you two illustrations: First, the average anesthesia time required for a total knee replacement:

Time (Minutes)	No. of Responses	Percent
60-120	14	16.6%
135-150	17	20.0%
152-180	17	22.5%
200-240	19	26.2%
250-335	13	15.6%

Time ranged widely from a low of one hour to a high of more than 5-1/2 hours.

The average time required for transurethral resection of the prostate:

Time (Minutes)	No. of Responses	Percent
30-60	18	21.4%
63-85	17	20.2%
90	22	25.9%
93-120	19	22.5%
121-220	9	10.8%

Again, time ranged widely from 30 minutes to more that 3-1/2 hours.

As I will discuss in a few minutes, the current method of reimbursing anesthesiologists under Medicare -- the relative value guide (RVG) system -- is totally patient-specific. DRG's would inevitably not be patient-specific: by definition, they provide a flat amount of money for physician services to a patient, no matter what the actual input of services. There is simply no doubt that the DRG method will create major inequities in the individual case, for the physician, the patient and indeed the Medicare program itself.

C. Inappropriateness of the "efficiency" concept. The argument is made that physician DRG's will create profit-based inducements to the DRG "gatekeeper" to provide care at the lowest cost consistent with quality. This notion, however, immediately raises at least two questions: What "efficiencies" or added "productivity" can be achieved in anesthesia care, and what minimum level of care is acceptable for Medicare patients who are to be anesthetized.

We already know that the anesthesiologist has little control over the surgical time devoted to a particular procedure, and that it is not the anesthesiologist who orders unnecessary or costly additional services or procedures for the patient. Where, then, does greater "efficiency" come from? The response of some individuals is that Medicare should force greater use of lower-cost nurse anesthetist services.

In our judgment, greater reliance on nurse anesthetist services -- particularly when those services are not personally directed by an anesthesiologist -- will represent a fundamental disservice to Medicare patients. The rendition of anesthesia care is dangerous work, requiring the judgment of a physician comprehensively trained in anesthesia techniques. The education and clinical training of nurse anesthetists simply do not qualify them regularly to provide anesthesia care on an independent basis, or indeed under the supervision of a surgeon or obstetrician -- who in recent years have received only minimal or no training in anesthesia care and who in any event are themselves occupied with the surgical or obstetrical procedure.

We regard nurse anesthetists, properly medically directed by an anesthesiologist, as valuable members of the anesthesia care team. We question whether anyone -- knowing of the complexities and risks of anesthesia care -- would willingly opt for the independent services of a nurse anesthetist over those of an anesthesiologist with many more years of education and clinical experience.

I should point out, moreover, that the current reimbursement system under Medicare already contains inducements for the provision of anesthesia services through the care team approach. Simply put, an anesthesiologist who assumes responsibility for simultaneously directing more than one nurse anesthetist is treated better under the Medicare reimbursement rules than an anesthesiologist who provides one-on-one patient service.

In this connection, the Subcommittee may be interested to know that according to a recent national survey conducted by our Society, two-thirds of our members reported that nurse anesthetists were involved in their practice. More than half of these respondents reported directly supervising nurse anesthetists on the basis of a one-to-two ratio, and an additional 20% reported a one-to-three ratio. Although I happen to believe that the best anesthesia care involves a one-on-one anesthesiologist-patient relationship, I would suggest that these ratios indicate that considerable "efficiency" consistent with quality already exists in the provision of anesthesia care to Medicare patients.

D. Competition. It has also been said that DRG's are desirable for RAP's because there is no effective competition among these specialists to induce them to provide lower-cost or more efficient care. Whatever may be the case in other specialties, this argument is increasingly losing its force in the marketplace for anesthesiologist services.

Since the decision by the Supreme Court in the Hyde case some three years ago -- upholding the right of a hospital to maintain an exclusive contract with an anesthesiology group -- we have been witnessing a radically increased effort by hospitals to sign anesthesiologists or anesthesiology groups to formal (and sometimes exclusive) contracts. Typically, these contracts are relatively short-term, tie hospital privileges to the duration of the contract (with no "due process" privilege termination rights), and in many cases, expressly limit the fees that can be charged to patients. Normally, however, they do not interfere with the right of an anesthesiologist to bill his or her patient on a fee-for-service basis, or seek to control the means by which anesthesia care is to be rendered.

Our recent survey of the ASA membership indicated that almost one-third of our members had entered into written contracts with their hospitals, and that of these, 75% were exclusive by their terms and about 20% limited permissible patient charges. I expect all these percentages to rise in the years immediately ahead.

What this means is that competitive forces are very much alive in the marketplace for anesthesiology services -- not necessarily between anesthesiologists or anesthesiology groups in the same hospital as formally advocated by our Society -- but between individuals and groups who would compete for these hospital contracts. With the Hyde decision, there is simply nothing to prevent hospitals from seeking bidders for these contracts, and given their own need to be responsive to opportunities to contract with the various alternative delivery plans such as HMO's, the hospitals have every inducement to continue to press for these contracts.

In the last analysis, it is because we believe the RVG methodology is so effective, and so fair to physician and patient alike, that we oppose the physician DRG proposal -- which is untested, is so apparently unfair in the specific case, and threatens to alter the direct physician-patient relationship.

II. Support for RVG-Based Fee Schedule

I believe that the Subcommittee may already be aware of the fundamental features of a relative value guide, or RVG. In its simplest form, an RVG is developed by assigning to each distinct medical procedure or service an abstract unit value, based principally on the complexity of that procedure, so that a table or schedule is constructed listing a series of procedures or services to which are assigned individual unit values demonstrating the relative complexity of each. In ASA's 1985 Relative Value Guide (a copy of which is submitted with this statement), for example, the following values are assigned:

Anesthesia for amputation of the lower leg	3
Anesthesia for procedure on the upper abdomen	7
Anesthesia for surgery on the lung	15

Anesthesia for lung surgery, therefore, is deemed five times more complex than anesthesia for a lower leg amputation, and slightly more than twice as complex as anesthesia for upper abdominal surgery.

A. Historical development of the ASA RVG. Development of the modern ASA RVG was evolutionary. In the early post-World War II years, it was typical for fees for anesthesiologists' services to be charged or reimbursed by third-party payers on the basis of 20% of the surgeon's fee. This method of determining anesthesiology fees was unsatisfactory to anesthesiologists, however, because it inappropriately correlated the difficulty and risk of the anesthetic procedure with the difficulty and risk involved in the surgical procedure, and did not adequately reflect the medical responsibility, knowledge or skill required of anesthesiologists. Further, it did not compensate the anesthesiologist for the time spent in administering the anesthesia -- a factor which worked to the disadvantage of many surgeons and their patients, since it created an economic incentive for anesthesiologists to work with fast surgeons as opposed to slower surgeons.

To alleviate this problem, many anesthesiologists who had established private fee-for-service practices began charging for their services on a straight time basis. However, because of the variability of the time which surgeons take to perform a procedure, third-party payers could not make meaningful comparisons of anesthesiologists' fees even for the same procedure.

To more fairly measure the medical services provided to the patient, anesthesiologists began in the 1950's to use an "anesthetic procedure" basis as a means of determining compensation. Under this method, a number of factors in addition to the time factor were considered in evaluating anesthesia services, including:

> -- factors relating to the anesthesic risk, including the patient's physical status and the degree of hazard imposed by the depth of anesthesia required, the type of anesthesia and technique and the potential complications incident to anesthesia;
>
> -- factors relating to surgery such as the magnitude of the surgical procedure and the degree of hazard imposed by the site of the operative field and the position of the patient; and
>
> -- factors relating to the technical skill required of the anesthesiologist, including problems incident to the maintenance of normal respiratory and circulatory physiology, and problems incident to specialized techniques and procedures.

The procedural method had the virtue of basing the evaluation of anesthesia services on the difficulty and risk of the anesthetic procedure as distinct from the associated surgical procedure, as well as the time involved. This development led to the ASA RVG as we know it today.

In a move to refine the procedural basis approach, the ASA House of Delegates, in 1961, charged its Committee on Economics and Fee Schedules with the task of constructing a relative value guide which would focus specifically on anesthesia procedures. Using the relative value studies of the California Medical Association as a guide as to form, the Committee recommended, and the ASA House of Delegates adopted, the first ASA RVG in October 1962.

Although ASA has updated its RVG on a number of occasions since 1962, the fundamental concepts have not changed: the Guide is based on two essential factors -- (1) the complexity, risk, knowledge and skill associated with each listed procedure, and (2) the time the anesthesiologist devoted to the procedure in question.

B. Complexity of procedure. With respect to the first factor -- complexity -- I should underscore the fact that the anesthesic complexity of an individual case simply cannot be correlated with surgical complexity. Since the concern of the anesthesiologist is primarily with the respiratory and cardiovascular systems, surgery related to these systems tends to complicate the anesthesia problem, and hence the relative values of anesthesia care for these procedures tend to be higher.

There is another ingredient of complexity which cannot be generically described in procedural terms -- that related to the physical condition of the individual patient who is anesthetized. The administration of an anesthetic to a patient with severe concomitant systemic disease simply carries a higher risk and requires greater skill than does performing the same procedure on a healthy patient. Thus our more modern guides have contemplated the addition of "physical status modifier" units to the basic unit relative value describing a particular anesthesia procedure. Our current Guide also contemplates the possible addition of "qualifying" units, where the procedure may be more complex or requires unusual skill.

C. Anesthesia time. The second factor of our RVG is time. In my description of the events leading to development of our first RVG in 1962, I have alluded to the limitations inherent in a relative value schedule which merely describes procedural complexity. Not only do different surgeons work at different rates according to their training, experience and skill, but also there are unpredictable complexities related to surgery and/or anesthesia involved in an operation -- over which the anesthesiologist has no control. Such complexities can lengthen a procedure beyond the time range normally anticipated. Thus, our guides have included time units in addition to base procedural units -- normally one time unit per fifteen minutes of anesthesia time.

Since there is a close correlation between anesthesia time and the operating room time routinely recorded in the operating room log in virtually every hospital, anesthesia intra-operative time is easily verified. The pre-operative and post-operative time spent in evaluating and caring for the patient, though highly variable, is accounted for in the base procedural unit. Invariably, complex procedures associated with high base unit values require a detailed, time-consuming pre-operative evaluation.

We regard the time factor as enormously important in providing a fair and accurate definition of the anesthesiologist's services. As I noted earlier, data available to us indicates that there are radical variations in time devoted to a particular procedure -- so radical that in our judgment, "averaging" of time in any payment system would more often than not create significant distortions.

D. Creation of a fee schedule. So far, I have described the RVG merely as a descriptor of anesthesia care provided to individual patients. As I am certain you are all aware, only one additional factor is required to convert an RVG into a fee schedule -- establishment of a unit's dollar value, or "conversion" factor. If the conversion factor is set at $25, for example, all a physician needs to do in establishing his charge, or a third-party payer in establishing the amount it will pay, is to multiply total units by $25.

Let me illustrate. In the case of an appendectomy on a healthy 66-year-old man, requiring one hour, the total fee or allowance ($250) is determined as follows:

Base Units.....6
Time Units.....4
Modifier Units.....0

10 x $25 = $250

The fee or allowance for the same procedure on a very ill 66-year-old man with a ruptured appendix and peritonitis, taking one hour and 45 minutes, would be $375, calculated as follows:

Base Units.....6
Time Units.....7
Modifier Units.....2

15 x $25 = $375

It should be noted that ASA is not in the business of establishing or recommending conversion factors. As stated in the preamble to our relative value guide, we intend that the RVG be only a procedural guide, and we do not include suggested conversion factors. Physicians and third-party payers are free to accept, reject or modify the guides that we publish. We are in fact aware that private insurance companies and Medicare carriers throughout the country use a variety of relative value guides as descriptors of anesthesia services.

E. Medicare's use of the RVG. I would now like to review with you our experience with use of the relative value guide, or guides, under the Medicare program. As you know, that program was established in 1965, and by that time ASA had already published its first Relative Value Guide. Indeed -- although not previously mentioned -- part of the impetus for publication of the 1962 Relative Value Guide came from the federal government prior to inception of the Medicare program: in 1956, Congress enacted a program for the delivery of health care for dependents of military personnel using physicians in the private sector, and the administrators of that program requested ASA to develop a systematic method of evaluating anesthesiology services.

From the inception of the Medicare program, relative value guides -- including those developed by ASA -- were used by the various carriers as a basis for defining customary and prevailing fees and determining reasonable charge screens. Many if not most of the carriers were already familiar, in their capacity as private insurers, with the RVG approach to setting and judging anesthesiologists' fees. Although Medicare authorities initially gave carriers only limited instructions on the use of such guides, this methodology rapidly became the principal basis for determining anesthesiologist reimbursement under Medicare. In 1983, by regulations issued pursuant to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), HCFA virtually mandated use of the RVG by its carriers for evaluating anesthesiology charges.

Use of the relative value guide methodology under Medicare has become the established reimbursement mode for anesthesia care and has proven a highly valuable tool for the Medicare authorities. Let me give you some examples.

-- In adopting the TEFRA reimbursement regulations for anesthesiology services, it was obvious that there should be a differential in reimbursement of an anesthesiologist who medically directed nurse anesthetists employed by him as distinct from an anesthesiologist who medically directed nurses employed

by the hospital. In the former case, he was bearing the cost of the nurse's services; in the latter, he was not. Based on its own research and input from ASA, HCFA determined that in the case of an anesthesiologist not employing the nurse, it would allow the anesthesiologists only half the time units it would allow one who did employ the nurse, that is, the former would be allowed only one time unit for thirty minutes, rather than one per fifteen minutes.

-- Last year, in attempting to develop, pursuant to its "inherent reasonableness" authority, the appropriate level of reimbursement for anesthesia care in connection with changing techniques for cataract surgery, HCFA determined that its carriers were generally allowing eight procedural units for such anesthesia care and, after discussion with ASA, research and public comment, lowered the maximum number of units it would allow to four. In effect, HCFA was engaged in a traditional RVG revision exercise -- it determined that in comparison with other procedures, anesthesia care for cataract surgery should be given a unit value of four, rather than eight.

The following language is drawn from the preamble to HCFA's notice of rule-making on the subject (51 F.R. 35893): "Under any of the various commonly used relative value guides, the number of anesthesia base units assigned to most surgical procedures performed on an ambulatory basis [such as cataract surgery] is three units. We allowed an additional unit for cataract procedures . . . on the premise that the service is complicated by the location of the surgery, which restricts access to the patient's airway and requires surgical field avoidance."

I should further note the important point that use of our RVG frequently results in "automatic" savings to the Medicare program. With improved surgical techniques, anesthesia time is often reduced. When this happens, the number of reported time units is also reduced, which is reflected in the total charge.

A prime example of decreased charges resulting from the use of the RVG is seen in the case of pacemaker implantation. Previously implanted through an open chest requiring two to three hours of anesthesia time, pacemakers are now inserted through a vein in an hour or less. Because of these procedural changes, base units declined from 20, to 15, to 6. Time units decreased from 8-12 to 4. Fees then, including modifiers, are now calculated on the basis of approximately 12 units, rather than 30 to 34 units.

F. Problems with use of the RVG under Medicare. In its initial report, the Physician Payment Review Commission has recommended the development of fee schedules for paying for physician services to Medicare patients. In testimony before the Commission last month, I offered the Society's support for this recommendation, and added the recommendation that the schedule be based on an appropriately drawn relative value guide.

I will not tell you, and I did not tell the Commission, that we believe the current Medicare RVG system for anesthesiology services is perfect. Indeed, it is flawed in our judgment by (1) the use of several different RVG's by Medicare carriers -- making the expression of national reimbursement policy more difficult -- and by (2) the fact that Medicare reimbursement rates (that is, conversion factors) radically and irrationally differ in different parts of the country and, in general, lag well behind the rates paid by most private insurers.

We regard the use by HCFA carriers of a multiplicity of guides to be a serious emerging problem. It means that (even before one gets to the question of appropriate conversion factors) determination of base units and modifying or qualifying units will vary from carrier to carrier -- when in fact there is no rational explanation for the differences. Anesthesia for surgery on the lung, whether provided in New York or Tucson, involves the same anesthesia complexity and risk and thus should carry the same number of base units.

III. Creation of a Uniform RVG-Based Fee Schedule

Our RVG, periodically updated, has set forth the Society's best judgment on relative values of procedures and appropriate modifiers, to be applied regardless of location or setting. Because of antitrust concerns, however, we are powerless to compel any physician or carrier to use our Guide, and expressly disclaim any intent to do so.

In part, our support for the work of the Physician Payment Review Commission stems from our belief that the Commission provides the framework for establishing a uniform RVG-based fee schedule for use by all Medicare carriers. This should involve input from all concerned -- physicians, insurers, and beneficiary groups. Following creation of such a schedule, we can then envision an ongoing process by which appropriate adjustments in the RVG, indicated by changes in technology or development of new techniques, can be negotiated between the Health Care Financing Administration and responsible physician, beneficiary and third-party payer groups. Such a procedure might well require limited antitrust exemption for participation by medical organizations, but in our judgment, the end result would be far more rational and equitable than it is now.

We are equally concerned by the current crazy-quilt pattern of carrier-authorized conversion factors. Our specialty has been criticized for its relatively limited acceptance of the Medicare participating physician option. I believe this is due in part to the historically low level of authorized conversion factors paid by Medicare carriers in several states. Much of the original carrier data on prevailing charges, developed in 1972 for purposes of the MEI program begun in 1975, was clearly inadequate or incorrect for a number of areas. Yet it is that data which forms the basis for 1987 carrier reimbursement decisions.

Longer term, we believe that development of a more intelligent reimbursement system lies with the work of the PPRC, and we encourage the Subcommittee to provide the Commission with the resources necessary to complete that work as rapidly as possible. For ourselves, we are happy to continue to cooperate with the PPRC to that end, just as we are currently participating in the Harvard-AMA study on a resource-based RVG.

A uniform RVG-based fee schedule makes sense not only for sound Medicare reimbursement policy reasons, but also for budgetary purposes. The impact on Medicare spending of changes in a uniform RVG-based fee schedule would be easy to calculate, particularly if greater rationality is brought to the levels of authorized conversion factors in various parts of the country. Although we may never reach the point where Medicare or the Congress could fairly establish a single conversion factor for national application, we do believe that far greater uniformity and rationality can be achieved than now exists.

IV. Current Budget Issues

I know, however, that the Subcommittee is currently concerned with development of the means to achieve budget savings in FY1988. We have told you our reasons why we believe physician DRG's are not the answer. We believe that until the work of the PPRC is completed, Congress should achieve any needed savings under Medicare Part B by applying reimbursement restraints across all physician groups, and not just a few.

Changes in physician payment inevitably raise questions about balance billing. While current law contains restraints on balance billing through the use of the maximum allowable actual charge (MAAC) and the "inherent reasonableness" process, perhaps Congress may wish to consider an income-related assignment system.

In sum, we oppose the physician DRG proposal, support the development of a fee schedule based on an RVG, and are prepared in the short term to work with the Congress on any reasonable broad-based budget savings proposal. I am happy to respond to your questions.

Chairman STARK. There is a vote. Would you like to recess for 5 or 10 minutes? We will be right back.

[Recess.]

Chairman STARK. I think that we are now ready to proceed and hear from Dr. Marasco. Please proceed.

STATEMENT OF JOSEPH A. MARASCO, JR., M.D., PRESIDENT, AMERICAN COLLEGE OF RADIOLOGY

Dr. MARASCO. Thank you, sir. Mr. Chairman and members of the subcommittee, I am Dr. Joseph Marasco, Pittsburgh, PA. I am president of the American College of Radiology, and I appear today to represent my 20,000 colleagues who are members.

Mr. Chairman, I have a prepared statement I would like to submit for the record, but I ask the chairman's permission to make some additional comments at this time.

Chairman STARK. Without objection, your entire prepared statement will appear in the record, and you may expand on it or supplement it any way you are comfortable.

Dr. MARASCO. Thank you very much.

The American College of Radiology resents the hoax that is being perpetrated on the Congress and on the physician community in the form of the RAPs DRG proposal by the administration. The RAPs proposal is getting all the attention, while the real problems in Medicare physician reimbursement are ignored. We believe it is time to cut through the smoke screen and discuss the problems realistically.

When first proposed last fall the RAPs scheme sent the whole of medicine into a cyclone of concern and activity. Yet here we sit 5 months later waiting for the administration to back up its proposal. We first reacted to announcement of the RAPs proposal by identifying it as ill-conceived. Now due to the administration's silence and the lack of supporting facts, we conclude it was never meant to be conceived at all.

Apparently it was only designed to alarm and confuse, rather than contribute to constructive discussions. We speculate that concrete proposals have not been produced because of the inherent complicated nature of the proposal. If I have to fly from Pittsburgh to Washington I am not routed through Oakland. The RAPs proposal is just that type of connection. The American College of Radiology is emphatically opposed to the DRG scheme for paying physicians. We believe it avoids the real issue.

We have taken a lot of lumps within the family of organized medicine because we declined to participate in seeking sponsors for the nonbinding concurrent resolutions which were introduced expressing opposition to this proposal. There is a possibility that we will even take more lumps because of the position that we are taking today.

But we are committed to a constructive dialog with the Congress. We want to be responsible citizens in the discussion of changes to the Medicare program. We do not want to sit on the sidelines without input, only to complain about the actions that you take.

We declined to participate in the resolutions because we believe in the institution of the Congress, and we believe that you and

your committee would provide a means of input if and when legislation was introduced on RAPs DRG. As physicians we are not trained to diagnose an unseen patient.

We were also relying on our previous experience with the Congress on this same RAPs DRG issue. On three separate occasions RAPs legislation had been introduced in the Congress. In 1965, 1967 and 1972 Congress considered this proposal and rejected it based on its lack of merit.

We also declined to participate because the resolutions called for postponement of discussion on reimbursement issues until a large number of studies are completed. Frankly, Mr. Chairman, we did not want to give the impression that we are enamored with some of the ongoing studies, particularly the Harvard RVS study which we believe, based on our attempts to be involved in the study, has serious flaws.

We believe the time is ripe for reform of the physician reimbursement system, and we believe there are positive ways to go about it. We are also concerned about Medicare beneficiaries. We call them patients. We are concerned because in addition to being physicians, we like you are taxpayers and citizens.

For these reasons we feel it is time to take a positive approach to discuss constructive alternatives that are fair to all concerned, provide value to the Government and patients, and assure access to quality care.

Let me make several points for the subcommittee's consideration. First, the American College of Radiology is opposed to physician DRGs and we are opposed to mandatory assignment. These two items are not negotiable. Those are our cards and we put them on the table. Past those two points, we are willing to work with the subcommittee, the Congress and the administration to achieve meaningful payment reform.

The current Medicare physician payment mechanism is a bad joke. Patients do not like it, physicians do not like it, and Congress does not like it. The current participating physician program under Medicare is also a joke. Based on my visits with our members around the country, I am surprised that our specialty has one of the highest participation rates. Once you elect to participate in Medicare your reimbursement becomes a crap-shoot.

And recently we have heard that as a further reward for participating, the administration wants to delay paying us for up to 27 days. The Congress and the administration should get serious about the program if you want to encourage participation.

Last week when the officers of the American College of Radiology met to discuss this testimony it was evident that everyone in the room had a contract with a carrier, or preferred provider organization that involved accepting assignment. No one voiced dissatisfaction with those plans.

The reason for the satisfaction is that there are negotiated fees that the carriers and the physicians agree are reasonable. The carriers pay promptly and paperwork for both patients and physicians is kept at a minimum. In other words, the system involves all the players and everyone is happy.

Mr. Chairman and members of the subcommittee, we believe there are reasonable ways to reach a mutually acceptable reim-

bursement mechanism for Medicare. Here are some of our suggestions.

End the use of usual, customary and reasonable method for determining physician reimbursement. The system has been so loaded, massaged, patched and forced that it no longer works to reflect the marketplace, as it was intended. It has become a procedural nightmare, which is a solid reason why most physicians fear making further commitments to the Medicare system.

Replace the UCR with an experience-based relative value schedule. You do not have to await or rely upon theoretical academic concepts which might be devised outside the health care system. These theories could interfere with delivery of medical care. The ACR and many other national specialty groups have skills to help Congress and HCFA to begin on this task immediately.

Amend Medicare to end the constant quarrels over deductibles and co-insurance. If Medicare carriers and private insurance carriers want to fight about what plans should pay and how much, get the patients and the physicians out of the middle. Let us simplify the system and not complicate it.

Empower the ACR and comparable organizations of other specialists to negotiate fee schedules based upon balanced and experience-based relative values, and give us an even playing field upon which to do it. If reasonable fee schedules were developed, you would not have to worry about a participation program, and it is possible you might even save money through administrative efficiency.

Support and strengthen the peer review concept. The early efforts have produced criticisms, many of them deserved. But there is no substitute for the necessary role of the medical profession in setting and judging the standards for medical care.

Improved utilization review is appropriate, remembering that increased utilization does not necessarily mean overutilization.

Mr. Chairman, these ideas are not radical. We believe that they are realistic. We, like you, do not have all the details available to us to map out a concrete route to reform, but we are willing to sit down and share in the decisionmaking. We offer the resources of our membership and staff in reaching toward useful solutions.

Thank you, Mr. Chairman. I will be glad to answer any questions.

[The prepared statement follows:]

Statement

Joseph A. Marasco, Jr., M.D.

President
American College of Radiology

before

U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Health

May 13, 1987

The Honorable Fortney H. Stark
Chairman Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
1114 Longworth House Office Building
Independence Avenue
Washington, D.C. 20515

Dear Mr. Stark:

The American College of Radiology presents these comments on behalf of its 20,000 physician and scientist members, specifically addressed to the issue of Medicare payments to radiologists, anesthesiologists and pathologists on the basis of diagnosis related groups.

Radiologists are physicians specializing in the use of x-rays and other forms of radiant energy to diagnose and treat diseases. As diagnostic radiologists we perform and interpret the majority of the 170 million medical imaging procedures performed on Americans each year. Radiation oncologists are responsible in whole or in part for treatment of two-thirds of all Americans who contract cancers. We work with our patients in hospitals, in our own offices and imaging centers, in medical clinics and in a variety of other medical settings. Overwhelmingly, we are in the private practice of medicine, setting, billing and collecting our fees on the same basis as other physicians.

The American College of Radiology is opposed to prospective DRG based Medicare payments for the services of radiologists, anesthesiologists and pathologists. In addressing the single paragraph in the Administration budget, which remains all any of us have of the RAPs proposal, we share the subcommittee's lack of legislative specific language upon which to comment. There are generic issues in the proposal which we will address.

The three specialties targeted in the Administration proposal are generally referred to as hospital-based physicians, a tired phase that has outlived useful purpose. While certain specialties may have limited their practice setting twenty years ago, present practice is considerably different. A large number of radiologists find that the majority of their practice is no longer based in a hospital setting. At the same time, a large number of other specialists and subspecialists, some of which didn't exist twenty years ago, have developed practice patterns which center a large portion of their practice in hospitals. Arbitrarily singling out a few specialties for a different payment scheme is an idea that ignores the way medicine is practiced in hospitals today.

The RAPs acronym should connote pride, rather than promoting a demeaning suggestion that we are a lesser breed than our colleagues in the rest of the medical profession. Our critics continually trumpet the old tired tune that we do not really take

care of patients directly and since patients are referred to us, without specifically choosing us, we should be treated in some different fashion. These assertions are half-truths that totally miss the point. Most patients, when referred to a specialist of any kind, follow the recommendation and guidance of their primary care physician and do not usually make that choice. Clearly, this system has worked and worked well.

In our efforts to understand what the current RAPs proposal might entail, we have communicated with Administration officials and with others who are contributing to the dialogue. We believe the immaturity of the concept has contributed to the difficulties in developing a legislative and programmatic concept.

While specifics are elusive, a central theme is the question of increased utilization. Proponents of RAPs DRGs point out that even with a fee freeze in place, total expenditures for physician services increased. Some suggested that physicians were gaming the system by creative billing to keep their incomes up to pace. Others suggested increased utilization of services to produce more income.

We were not surprised by these increases. The mandate of TEFRA to separate the expenses of Part A and Part B caused an expected shift in services away from the expensive hospital setting. An increase in beneficiaries also played a part. It is our belief that neither the average charge per service nor the number of services per medical case increased dramatically during the fee freeze period. There are certainly factors which would increase utilization, such as sicker inpatients and the ongoing problems of professional liability, but we can not accept the suggestion that any increase in utilization is inherently over-utilization. Appropriate use of medical services should not be arbitrarily regulated by the reimbursement system. The decision on medical appropriateness should be a function of an effective peer review system.

There are two additional considerations in discussing the utilization of radiology services. Radiology is primarily a referral based specialty. While radiologists may guide the primary care physician in choosing appropriate studies, they do not generally produce their own patients. The RAPs proposal places radiologists at risk, even though demand is created elsewhere.

Another factor in the discussion of utilization is the fact that all radiology is not done by radiologists. Seeking ways to control the number of imaging procedures performed by radiologists ignores a large portion of total medical imaging. Primary care physicians must make a choice whether to seek consultation on an imaging study or to perform the study themselves. In recent years, equipment manufacturers advise us that they enjoy brisk sales of x-ray units, isotope scanners and ultrasound devises to primary care physicians for installation in offices. These other players must be considered in any discussion of utilization of radiology procedures.

We must add with dismay, that our initial examination of HCFA's 1984 Part B billing files indicate a tendency for the allowable charges for some of these other physicians to be higher than those for a qualified radiologist for the same examinations. We would suggest it inappropriate to pay these physicians more than Medicare pays the qualified specialist.

There are other reasons upon which we base our objections to the RAPs DRG proposal. We believe the proposal would force

radiologists into unreasonable economic combinations. The The practical problem of reversing the major provisions of TEFRA of 1982 are staggering and the lack of parallelism among the three targeted specialties would create unnecessary confusion. The general lack of practice structures readily available to respond to the RAPs proposal leads us to doubt that meaningful program efficiencies and savings would be realized.

The RAPs DRG proposal would tie hospitals and physicians together against the medical interests of the patient. The DRG mechanism brings powerful pressure on hospitals to minimize institutional services and length of stay. At present, the physician's indepedence from these pressures provides a needed balance. Placing a similar downward pressure on physician motives could deprive the patient of elements of good medical care in the name of economy and could force procedures out of the hospital setting to sites of service unresponsive to peer review, patient convenience and quality assurance mechanisms.

RAPs DRGs would not benefit the program, the physicians or the patients. But in arguing against this particular proposal, we recognize that Medicare must change to meet patient needs and national imperatives.

Along with others, we have concluded that Medicare program efficiency and cost savings would be improved by termination of the UCR method of determining payments to individual physicians. That system has grown enormously cumbersome with the addition of indexes, percentiles, profiles, maximum allowables, Gramm-Rudman discounts and the natural tendency of carriers to impose their own systems on their Medicare business. As we mentioned last summer, it borders on the impossible for any physician to understand how the carrier arrives at his fee profile.

Of the available alternatives, we favor the adoption and use of relative value scales. Until we were deterred from such activities by the Federal Trade Commission a decade ago, we had developed relative value scales for radiology which were generally used and widely acclaimed by health insurance carriers. The experience and methods by which ACR and many other medical groups developed such scales is available to the Congress and to HCFA upon request. They are based upon experience, rather than the theoretical approaches contained in some of the studies now underway.

A simplified system of setting fees would result in improved carrier performance without increased costs. It would reduce the incentives for physicians to game the system and increase the incentives for physicians to become participating physicians. Medicare reported most recently that some 40 percent of radiologists are participating physicians and that a substantially higher number of radiology charges are billed on an assignment. But we must observe that accepting assignment in the current confusion is more an act of good faith and intent than a sound business decision.

As private practitioners, we hope and urge that the subcommittee resist pressures to make Medicare assignment mandatory. Like most national groups, we have urged our members to accept assignment whenever possible. However, the right to accept or reject assignment for one or for all Medicare patients is a right we prize highly. We would resist losing it.

The Congress is properly concerned about Medicare costs. It should be equally concerned about Medicare quality.

The concept of quality has three main dimensions. One is determination and provision of needed services. Two is elimination of unneeded services. Three is assurance that needed services are delivered by properly qualified physicians and allied health personnel.

In the past two decades, this organization has worked with the Food and Drug Administration, with the Blue Shield Association and with other medical groups to make recommendations for appropriate use of medical imaging procedures. As examples, we have recommended against chest x-ray screening of the population, against routine chest x-rays for patients being admitted to hospitals and we will shortly recommend against routine chest x-rays before surgery. Conversely, we recently recommended that health insurance plans expand their coverage to pay for screening mammography for women over the age of 40. In each case, we based our recommendation on medical considerations. But each one will save money for patients and health coverage programs.

Recently, the Congress created the peer review organization function within Medicare to provide for oversight of the way Medicare beneficiaries have been treated. Thus, the PRO programs needs help. But if the medical profession is serious about improving the quality of care by its members, we must ask the Congress for more, rather than less, support for setting and implementing medical standards by physicians for physicians. Such action will be beneficial to program expenditures, as well as program services.

Sincerely,

Joseph A. Marasco, Jr., M.D.
President

Chairman STARK. Thank you. Let me just follow up. If you have copies of your supplemental remarks, I would certainly like to see them, Dr. Marasco.

You said you are opposed to assignment. Then you mentioned that in most communities your groups will negotiate with the Blues or preferred provider systems in what is virtually an assignment system.

Dr. MARASCO. I am opposed—we are opposed to mandatory assignment. We believe that given proper incentives——

Chairman STARK. Okay, but now what I am trying to get at is what is the difference? Then I thought you said somewhat after that, that in fact in many areas your group, radiologists, will negotiate with a preferred provider or the Blues in what is, in effect, a mandatory assignment relative to the patients that those intermediaries serve. Is that——

Dr. MARASCO. That is true, but it is entered into on a voluntary negotiated basis. It is not a mandatory system.

Chairman STARK. Okay, so what you are saying is that you would have no problem with an assignment system as long as you all could negotiate it, either regionally or nationally or some other way with, in this case, I suppose HCFA.

Dr. MARASCO. Yes, and provided that those few members who, for various reasons the assignment system may not appeal, have the right to not be included mandatorily in the system. As long as that right is reserved.

Chairman STARK. Let me ask you this. Let us suppose that we will stick an amendment someplace in legislation and we will direct HCFA to negotiate with any subspecialty it chooses or that chooses to negotiate with HCFA for a fee schedule that they can work out in a mutually agreeable manner. Would you be willing to go over and sit down with Dr. Roper and his gang and try and negotiate that?

Dr. MARASCO. If that is the Congress' determination.

Chairman STARK. All we would have to do is give them authority. We are not even mandating it. There is some question today that they have the authority. It would not take more than a paragraph—just give HCFA the authority to negotiate fee schedules with groups of physicians. You could go over and sit down and hammer out something.

I mean, would you feel comfortable? It would not bother me. I am suggesting that that might be one answer to our dilemma, and let you go ahead. Now you might all decide you want to do it regionally. I do not know how within your subspecialty you guys want to handle that. But HCFA wants to save money. We would generally have some oversight if you got off into some dangerous ground that would——

Dr. MARASCO. Well, there are legal problems for us because we are under a consent decree. As long as we can get around that, you can help us with that, I think——

Chairman STARK. I think we can work that out all right.

Dr. MARASCO. Okay.

Chairman STARK. Let us just assume for a minute that we could very simply say, you go negotiate with HCFA, just the radiologists. Would that not be a good place to start? Why go to us? I mean,

they have got experts at HCFA who could do that. Would that make you uncomfortable?

Dr. MARASCO. Sounds reasonable to me, as long as we have an even playing field and the cards are not stacked against us.

Chairman STARK. You do not have to agree. I mean, the point is, if you guys cannot agree we are right back where we are today, right? But it seems to me that if we just said to HCFA, go ahead, see what you can negotiate and see what they can come up with.

I cannot believe that they are going to come up with something that is going to waste a lot of taxpayer's money. And I cannot believe that you are going to buy into anything that only 2 percent of your members would agree to. I mean, get your guys to the table and start negotiating. And I think I would rather they than us.

We should not be doing that. We should just sort of set the broad guidelines and let you all negotiate. I have no quarrel with that. And I think that is a refreshing and cooperative and creative approach to accomplishing what we are trying to do, and I appreciate your being very straightforward.

I have some more questions I am going to hold because I know Mr. Gradison is anxious to talk to you because that was really his idea and I just stole it from him. But I will yield to my colleague from Ohio on that topic or anything else.

Mr. GRADISON. Thank you, Mr. Chairman. I have been troubled by the confrontational nature of the relationships that exist today, and I think we all have been trying to figure out a way to develop a solution to these problems. And I am not sure whether the one that the chairman mentioned would work, but we are glad to get your reaction. It might be worth a try.

Having suggested a nonconfrontational approach, I am going to now pursue a slightly more confrontational one just to try to draw you out. That is the spirit in which I ask these questions.

Do each of you have within your professional organization, members who work on a salaried basis for HMOs?

Dr. ZAUDER. A very small number.

Mr. GRADISON. You have some.

Dr. ZAUDER. A very small number.

Dr. ZASTROW. Some.

Dr. MARASCO. Same.

Mr. GRADISON. Do each of you have members of your organization who work on a salaried basis for the Veterans Administration?

Dr. ZAUDER. Yes.

Dr. ZASTROW. Yes.

Dr. MARASCO. Yes.

Mr. GRADISON. Do each of you have members of your group that work on a salaried basis in military hospitals?

Dr. ZAUDER. We have military members.

Dr. ZASTROW. Certainly.

Dr. MARASCO. Yes.

Mr. GRADISON. Could you tell us in what way the fact that they are on a salaried basis interferes with the patient relationship with access and quality and the other things which your testimony says you are worried about if they were, in effect, on a salaried basis? What is the actual experience out there that leads you, from the

experience of your own members to believe that these dire forecasts——

Dr. ZAUDER. Well, I think, Mr. Gradison, we have to look at several things. If you look at the teaching hospital, my environment, I am not paid by the hospital to deliver patient care. I am paid to teach medical students and graduate students and the like. Any income that I derive, and certainly to support my department and my faculty I must, is derived from patient care. We could not exist without that money.

So that what we get paid for teaching is a separate issue. I have half again as many people as I would need to run the department were I working strictly on a fee for service basis and did not have teaching responsibilities for the medical school.

I think that when one looks at the military and the Veterans Administration, as far as we are concerned, it is the type of personnel that they attract and I am not too sure that the quality of care is the same. And I say that with due respect to the fact that they are government employees.

Mr. GRADISON. How about the HMOs, where your members work?

Dr. ZAUDER. I do not think that I have enough experience with that to be able to comment.

Mr. GRADISON. Let me try this another way. The testimony suggests that all three of you are convinced that, say if we paid the hospital and RAP's entered into perhaps salaried arrangements, that it is going to be detrimental to the patient, to the physician-patient relationship, and to quality and access.

And all I am really asking you is, what evidence do you have, presumably from the experience of your own members, that leads you to say that? Or is this a theoretical concern? I can understand you are worried it might happen, but do you have any evidence that it is happening where salaried arrangements exist today?

Dr. ZASTROW. If I might, Mr. Gradison. I, as part of some functions that I have at my institution, I happen to be chairman of the cost containment or so-called DRG committee. And there is no question in my mind that what you are proposing would align the incentives of the hospital-based physicians with the incentives of the institution.

As you know, the complaints of AARP is one of discharge early and quicker. My role as chairman of that DRG committee is to try to minimize those effects while still following the needs of the hospital. That would be lost in this kind of a situation where my incentives for less care would be aligned with the hospital.

Mr. GRADISON. Is it lost today when you have members working, as you said you do, in HMOs, military hospitals and VA hospitals?

Dr. ZASTROW. I hope not, but you have to remember who is paying the piper, and to whom that person will answer. There is no question I answer to the hospital administrator as well. My contract could be terminated in 30 days. But he who pays the piper, chooses that tune.

Mr. GRADISON. I am just puzzled by all this because my impression is that before the government tilted some of this system, particularly with regard to pathology, away from joint billing into separate billing that there was more of it. That in some parts of the

country more than others, and in certain kinds of institutions more than others, that salaried arrangements were the norm rather than unusual.

I am not suggesting it was ever a very high percentage, but I just do not remember hearing complaints that those arrangements led to deterioration of the quality of patient care or breakdown in the relationships or lack of access. My sense of it, to be frank with you, was that the professional training and standards of your fields were such that the method of payment really did not affect, and would not affect, and will not affect those very important relationships that you are talking about. And it is troubling to think that they might.

Dr. ZAUDER. As one, Mr. Gradison, who was brought up in the days when one cared for the indigent patient without regard to reimbursement, I think that the situation has changed with the imposition of the hospital DRG. A Medicare recipient is admitted to the hospital with a fractured hip. There is incentive to the hospital administrator, or he who works for the hospital administrator, to nail that hip immediately and get that patient up and out.

On the other hand, if I evaluate that patient, it may be quite obvious to me that that patient has several concomitant diseases that need to be treated before the patient comes to the operating room. It is the quicker and sicker concept that concerns us. And that situation did not exist before the hospital DRG.

Mr. GRADISON. I can understand the patient advocacy issue and argument very clearly, and you give us a good example of it.

Dr. MARASCO. As physicians, I think we want to have a relationship with patients, not with hospitals, although we have relationships with hospitals that are very obvious. I can give you an example of how a salaried arrangement could be detrimental to quality. It almost parallels something that happened in my career 15 years ago that made me decide never to work on salary again for patient care dollars. And I made that commitment to myself.

If a radiologist needs increased staff, and if he is salaried, he has to go and argue before the administration of the hospital for increased staffing. The hospital has pressure in many, many places economically. So they may say, we do not need the increased staff, we will just do with what we have.

So you strain the resources that you have, and you have the potential for a drop in quality in care. It does not necessarily mean it is going to happen, but the potential is there. It is much greater in that type of an arrangement.

Curiously, in our situation, whenever we went off the salaried arrangement we flourished, we increased staff, because we responded to need. And we did it because we knew that our peers in the medical staff would not tolerate less than good work. And I think that system works and works very well.

Mr. GRADISON. I thank you all very, very much. You have been extremely helpful. And thank you, Mr. Chairman, in your patience in letting me go beyond the normal 5-minute rule.

Chairman STARK. I want to just come back. You have all heard the previous witnesses indicate that they really do not think that there is a reason not to have assignment or not to negotiate directly with you rather than with the patients because they really did

not find any evidence that you negotiate with the patients. You may see them, but not necessarily negotiate the fees.

But I think the major issue was addressed by Dr. Marasco. We are faced with wanting to somehow contain costs. Beyond that we have the same concerns for the patients or beneficiaries that you do, and obviously the same concerns for quality. And I think again Dr. Marasco hit it right on the head. If we can set those aside, if we can stipulate to the fact that we want quality, indeed will not tolerate second-rate quality, then it is a question of negotiating for how much you are going to make, and how much we are going to spend.

And it seems to me the sooner we can get to that, the less time we are going to waste, because at some point we have to do it. If we do it, as the administration has done it in past years by freezes, and sort of across the board cuts, you take your chances. And I do not say that in a threatening sense. I do not like doing that. That is a kind of meat axe approach. Politically, it is a lot simpler, just to say, let us freeze everybody, and then you and the hospitals and the nurses and the whole gang get your income frozen. You have to find ways to increase it, which you instinctively should do and will do.

If we can begin to negotiate, or HCFA—I do not really care about Congress getting into this hassle, except in the broadest sense of perhaps setting some guidelines—then I think we should get on with it. And not everybody is going to want to do it.

I do not see any way to make it mandatory. I think that is a threat, but you get much more of that from the States. If I wanted mandatory assignment in California, I would be out on the streets right now getting signatures on a referendum. And I bet I could do it. All you have got to do is get Jimmy Roosevelt and the clowns that work in that organization to get the seniors ginned up and you would not stand a chance. I could get mandatory assignment through in California so fast it would make your head spin. But I would do it in the streets and the supermarkets, not in the halls of Congress.

And I do not think you want that and we do not want that. I am just suggesting that if you can find a way that you are comfortable with and not lose your membership or lose your position within your trade association or professional group or whatever it is, then I would urge you to start negotiating. It does not have to be with the chairman of this committee or that committee, it could very well be with HCFA.

I just have to commend Dr. Marasco, I think that if we could start doing that, we could get someplace. And I say that—and I wish my entire committee was here so I could lecture them along with the administration—that from our end, we have got to be able to convince you we are going to be forthright in our negotiations and stick to a deal or we cannot expect you to do that.

What has gone on in the past was not the doings of this subcommittee. And I think that the present administration in HCFA recognizes that what went on in the past in terms of keeping their word was less than adequate. And Dr. Roper testified to that, and I have a hunch that Dr. Bowen would agree.

If we expect to work something out, we are going to have to work it out in good faith. And you are going to have to be able to expect that we will keep our end of the bargain. I assume you do that with Blue Cross and Blue Shield. I mean, you used to be them, so why should you not expect them to keep their word. And I think we have got to be able to present the same opportunity to you from that portion of your fees that come from Medicare, then I think we will get somewhere.

I hope we can do it. I do not know what the administration is going to propose. We are going to look at it. I would rather get started with a program that will work, if we are going to do something this year. I do not think waiting for the relative value scale is going to get us anywhere. To me that is, purely and simply, a stall disguised as a study. And we tend to be very skeptical about turning things over to commissions and studies and the rest of it.

It seems apparent where we are going. Let us get on with it, and let us make it as good a deal as we can. And that is what I would like to do. I am sure you know, I have seen many of you as has our staff, and we were more than willing to negotiate and to try and learn and try and work something out.

I have some sense we may make some progress that way this year. The tension does not bother me in the negotiation. If you do not let it become contention, why, we will probably be all right.

So thanks very much for participating. I know the whole focus has been on you three, and that is kind of somewhat unfair to build up all these witnesses who have been dumping on you all day and not having the committee here to hear your defense. But believe me this is, as I am sure several of you know, you are always welcome to work with our staff who will look forward to working with you more as the year progresses.

Thanks very much.

The hearing is adjourned.

[Whereupon, at 5:35 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

RE: Medicare Payment for the Inpatient Services of Radiologists, Anesthesiologists and Pathologists Based on Diagnosis Related Groups

May 26, 1987

The American Medical Association is pleased to submit this statement for inclusion in the record of the hearing held by the Subcommittee on May 13, 1987 on the issue of Medicare payment for inpatient radiology, anesthesiology and pathology (RAPs) services based on diagnosis related groups (DRGs).

The AMA is unalterably opposed to a DRG-based physician payment plan. Such a proposal continues the recent piecemeal and shortsighted steps taken or proposed for the Medicare program that are designed only to achieve arbitrary budget savings without consideration given to the impact of these changes on either the beneficiary or the physician. We urge you to reject any RAP proposal.

While we continue to have serious reservations over many of the recent legislative modifications in physician reimbursement under Medicare, we strongly support the direction taken in the last two Reconciliation Acts calling for a thorough analysis of physician reimbursement under Medicare and the development of a resource-based relative value scale (RVS). This activity is designed to rationally review how physician services are valued. Modifications in reimbursement under Medicare, including RAPs, should await the completion of this study.

Before addressing the specifics of the RAPs proposal, we feel it is imperative again to remind the Committee that the Medicare program is still rapidly heading into bankruptcy. While we recognize the need for short-term savings to shore up the Medicare program, overall Medicare reform is necessary to assure the existence of a sound health care program for all of the coming generations of elderly. The AMA has

developed detailed proposals, both short-term and long-term, that address these issues and present rational proposals for Medicare reform. It is time to put Medicare reform on the front burner and to remove this program from the annual series of program cuts that are aimed solely at generating arbitrary budget targets that ignore the detrimental impact on access to and quality of care.

DRG-based Payment for Radiology, Anesthesiology, and Pathology Services (RAPs) Provided to Hospital In-patients

Congress examined the payment for hospital-associated physicians at the time that the program was created and properly recognized their role under Part B of the program. In Congressional testimony prior to the enactment of Medicare in 1965, the AMA stated that the services of pathologists, radiologists, physiatrists, and anesthesiologists should be reimbursed on the same basis as other physicians. That statement (May 11, 1965 - Senate Finance Committee), set out below, certainly is true today.

> The services of pathologists, radiologists, physiatrists, and anesthesiologists are professional medical services performed by physicians. The fact that their practice is largely in the hospital is incidental. These are not hospital services, and they do not belong in a program designed solely to offer hospital benefits. All physicians want to be responsible to their patients to the limit of their competence; they cannot be restricted by decisions of non-medical personnel on what services should and should not be performed in medical facilities.

A DRG-based approach to physician payment is inconsistent with the above Congressional treatment and recognition of RAP services and remains totally untested. Every indication is that such a system will be detrimental to both access and quality. As the DRG payment for physician services would be based on an "average" for the mythically "average" patient, the program will increase the already tremendous hospital driven economic pressures for withholding care in the hospital.

- Incentives caused by hospital DRGs already have limited the availability of services, as evidenced by nursing and other services having been pared by hospitals. RAP DRGs will create new incentives to now limit access to physician services.
- By basing payment for both physicians and hospitals on DRGs, all of the economic incentives will be weighted against the patient, i.e. by providing fewer services, the hospital stay becomes more "profitable."
- DRGs do not pay for services actually rendered; in fact, they reward for services not performed. This mechanism will reinforce existing hospital incentives to reduce available care and avoid severely ill patients.

- RAP DRGs are unnecessary as a means for controlling utilization. Medicare now has the authority to deny payment where it determines that a service is not "medically necessary."

- Beneficiaries who use little or no services will be penalized by having to pay higher coinsurance than under the current system, while those who use substantial RAP services will benefit from a fixed coinsurance that is unrelated to the services received.

- Access to care in rural areas will suffer. RAP physicians will be discouraged from providing services in areas distant from their primary site of practice. Many rural hospitals already experience hardships due to the existing DRG payment methodology. It is dangerous to further expand the DRG payment to services provided in hospitals already in crisis.

- The savings attributed to this proposal cannot justify the resulting disruption in patient care activities and the serious risk patients will face by their loss of access to RAP services.

- RAP DRGs will be detrimental to patient care by driving a wedge into the physician/patient and physician-to-physician relationships.

In addition to these points, experts on physician reimbursement issues outside of the medical community have indicated strong concerns over physician DRG proposals.

- Implementation of a physician DRG system would too closely align the incentives of physicians with hospitals. This might well result in the physician not continuing to be as strong an advocate for needed medical services to be given the beneficiary in the hospital, and reduced access of beneficiaries to hospital care if hospitals practice "skimming", i.e., admitting large numbers of patients who require less care than average for the DRG, while referring elsewhere beneficiaries who require more care than average. (Jennifer O'Sullivan and James Reuter, Congressional Research Service of the Library of Congress, Background Paper for The Senate Finance Committee, April 22, 1986)

- Close alignment of the incentives of the hospital with those of the medical staff could be very expensive for the current prospective payment system and might create access problems for potentially unprofitable patients. (Stephen F. Jencks, M.D. and Allen Dobson, Ph.D. [Office of Research, HCFA], New England Journal of Medicine, June 6, 1985)

- If physician DRG payments are made to the hospital and the hospital allocates funds to the physician, this would reduce the patient advocacy role of the physicians, and reduce his efforts to provide protection against excessive hospital cost cutting. (Stephen F. Jencks, M.D. and Allen Dobson)

- If the growth of Medicare costs is concentrated in outpatient services, as recent unpublished HCFA data suggests, an inpatient physician DRG system is less useful. (Stephen F. Jencks, M.D. and Allen Dobson)

- Implementation of a physician DRG system would not be feasible until a case-classification system suitable for physician services could be developed -- a very difficult task. (Congressional Budget Office [CBO] Report, "Physician Reimbursement Under Medicare: Options For Change," April, 1986)

- Physician DRG system would align physician incentives too closely with those of hospitals, with the result that physicians might not serve as effectively as advocates for beneficiaries. (CBO)

Finally, the Administration's proposal is not responsive to Congressional direction and is certainly premature. Congress has rejected and should continue to reject such major physician payment reform not backed by appropriate study.

- o Congress in 1983 called for a study and report on MD DRGs -
  - The report, due in 1985, has not been given to Congress. However, a draft of the unpublished HCFA report states: "DRG based payment to physicians is inadvisable because it would be difficult to put in place, complex to administer and unpredictable in its impact." (Emphasis added.)

- o Congress in 1986 created the Physician Payment Review Commission to study and report to Congress on physician reimbursement -
  - The Commission's first report was submitted on March 1, 1987.

- o Congress in 1986 called for a study and report on RAP DRGs -
  - This report is due by July 1, 1987.

House Concurrent Resolution 30, with widespread bi-partisan co-sponsorship (300 cosponsors as of May 13, 1987), clearly states that it is neither feasible nor desirable to implement any method of payment for physicians services based on DRGs. We urge all of the members of this Committee to join with us, the American Hospital Association, the Federation of American Health Systems, and your colleagues in speaking out against physician DRGs through support of this Resolution.

CONCLUSION

Opposition to the RAPS proposal is also strongly supported by the American College of Radiology, the American Society of Anesthesiologists and the College of American Pathologists.

Hasty actions in the physician reimbursement arena will result in unintended results that could prove detrimental to Medicare beneficiaries. The Congress has called for appropriate studies. These should be pursued and completed. We urge you to reject any RAP proposal.

STATEMENT

of the

AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS

to the

Committee on Ways and Means
Subcommittee on Health
United States House of Representatives

RE: Medicare Reimbursement for Pathology Services

May 29, 1987

The American Society of Clinical Pathologists (ASCP) appreciates this opportunity to offer its views on the proposal to reimburse services of pathologists and other medical specialists based on DRGs. ASCP is a nonprofit medical specialty society organized for education and scientific purposes. Its membership numbers over 45,000 board-certified pathologists, other physicians, clinical scientists and certified technologists and technicians. These professionals recognize the Society as the principal source of continuing education in pathology and as the leading organization for the certification of laboratory personnel.

The ASCP feels that a MD-DRG system for Radiologists, Anesthesiologists and Pathologists is an ill conceived, hasty and discriminatory answer to the comprehensive Medicare Part B payment reform which Congress set out to achieve. The ASCP is opposed to "RAP DRGs" and mandatory assignment. While there are problems with the current fee-for-service system, it has assured access and choice of high quality medical services for Medicare beneficiaries. The development of a relative value scale for weighing physician services could be a reasonable approach to a physician payment system and should deal with much of the inequities in the current system. Congress directed the Department of Health and Human Services to report on the development of a RVS by July 1, 1989.

While the ASCP understands the budgetary pressures facing the Administration and Congress regarding the Medicare program, we feel that the proposed restructuring of the reimbursement system for pathologists is inappropriate. The goals which such a radical restructuring were to accomplish--reduction in utilization and cost savings to Medicare--would not be achieved for the following reasons: 1) there is no evidence of a utilization problem for these three medical specialists; and 2) the services of these specialists are usually provided in association with the surgical services or medical inpatient procedures which they do not initiate. Estimated Medicare cost savings due to curtailment of volume would therefore come only as a result of withholding necessary services. We believe that there would be serious detrimental effects of such a proposed reimbursement system for RAPs. Some of the immediate problems of a RAP DRG system are:

1) The quality of medical services to Medicare inpatients would be threatened by the imposition of these additional substantial financial incentives against appropriate physician intervention in patient care. Physicians have played an important role in balancing incentives given to hospitals under the Medicare prospective payment system.

2) The likelihood of equitable payments to pathologists for medical services to inpatients would not be good. Medicare rules for billing and reimbursement of pathology services recently changed substantially. The Part B data base for pathology is in transition and already resulted in inequitable reimbursement for many pathology services which Congress has only just corrected.

3) A period of stability is essential to the future of pathology. The practice of pathology has undergone significant changes in the 1980s which is affecting the future supply of the specialty. The 1986 data from the National Residency Matching Program show a decline in pathology residency positions filled from 67 percent in 1983 to 58 percent in 1986. Disruption caused by TEFRA, the hospital prospective payment system/DRGs and rumors of a RAP DRG Part B payment system raises serious concern about the future supply of pathologists.

Finally, with regard to the discussion of balance-billing it should be noted that Pathologists have had a strong record of assignment. A recent HCFA study shows that approximately 50 percent of pathologists have signed participating agreements under Medicare. This is one of the highest participation rates of any medical specialty. Many physicians who do not sign participating agreements still accept assignment on 100 percent of Medicare claims submitted. The same study shows that as many as 17 percent of the 50 percent non-participating pathologists accept assignment on 100 percent of their cases. Many more nonparticipating pathologists accept Medicare assignment on a case by case basis. Market forces and beneficiary financial needs have already had a significant impact on pathology assignment rates. If Congress remains concerned about the pathology assignment rates, HCFA might be directed to examine why the minority of pathologists do not accept assignment (i.e., inequitable payment).

In conclusion, the ASCP is supportive of equitable reform of the Medicare Part B physician payment system for all medical specialties. Congress and the Physician Payment Review Commission appear to be on the right track with the development of a fee schedule payment approach. RAP services should not be singled out since all inpatient medical services are dependent on or related to such services. The ASCP stands ready to work with the Committee on an equitable and comprehensive Part B reform.

STATEMENT OF THE
AMERICAN SOCIETY OF INTERNAL MEDICINE
TO THE
SUBCOMMITTEE ON HEALTH, WAYS AND MEANS COMMITTEE
FOR THE RECORD OF THE MAY 13, 1987
HEARING ON FISCAL YEAR 1988 BUDGET RECONCILIATION
ISSUES RELATING TO PAYMENT OF RADIOLOGISTS,
ANESTHESIOLOGISTS AND PATHOLOGISTS
ON THE BASIS OF DIAGNOSIS RELATED GROUPS

Introduction

The American Society of Internal Medicine (ASIM) appreciates the opportunity to offer its views on paying for physician services on the basis of diagnosis related groups (DRGs).

Since its formation in 1956, ASIM has played a leading role within the medical profession in studying and formulating new approaches to paying for physician services. Considerable time and energy have been spent evaluating the efficacy of paying physicians according to DRGs. In March 1984, following passage of legislation which implemented prospective payment for hospitals and which also included a provision requiring the Department of Health and Human Services (DHHS) to study the advisability and feasibility of extending DRGs to physicians, ASIM released a comprehensive position paper on physician DRGs. In this paper, ASIM pointed out the lack of data on the feasibility of reimbursing physicians on this basis and the potential adverse effect on the quality of patient care. ASIM has reviewed the subsequent research on physician DRGs and would like to share its recommendations with the Committee.

Background on the Administration's Proposal

Diagnosis related groups (DRGs) are once again under consideration by policymakers as a basis of reimbursing physicians for care provided to Medicare inpatients. The Reagan Administration has put forth the most recent plan, proposing as part of its 1988 budget that payment for the services of certain hospital-based physicians--radiologists, anesthesiologists, and pathologists (RAPs) -- be determined using DRGs. An earlier version of this proposal that originated with the Office of Management and Budget recommended paying for all inpatient physician services on this basis. Strong opposition from Department of Health and Human Services (DHHS) Secretary Otis Bowen, MD, and the AMA, ASIM and other medical organizations resulted in the decision to limit the proposal to RAPs only. As an alternative, ASIM has advocated basing physician payment on a resource cost relative value scale (RVS), which Congress itself mandated in the Consolidated Omnibus Budget Reconciliation Act of 1985.

Under the Administration's proposal, Medicare would pay an average rate for the RAP services associated with a specific discharge. Estimates on actual savings vary, ranging from $10 million in FY'88 and $560 million over five years (DHHS) to $70 million in FY'88 and $1.2 billion over five years (Congressional Budget Office). Details on the nature of the Administration's proposal -- which services the payment is to cover, to whom the payment is to be made, how the payment is to be determined -- are not yet known.

In an MD-DRG system, Medicare could reimburse on a case basis for all or some inpatient services performed by physicians during a hospitalization. The amount of that reimbursement would be determined by the DRG in which the hospitalization was classified at discharge. Reimbursement could cover a specific episode of care, be limited to just inpatient care or broadened to include a specified period of time before admission and after discharge. Physician services could be packaged together with hospital services, and a single payment made for each case -- whether to the hospital or to a joint venture established by the hospital and its medical staff. Alternatively, a separate payment for physicians' services could be made either to individual primary care physicians or to the hospital medical staff as a group.

Advocates of MD-DRGs believe that this mechanism offers the prospect of controlling costs and increasing efficiency by paying a predetermined amount for some or all of the physician services provided during a hospital stay. The presumption is that physicians would have strong financial incentives to forgo services with little or no medical benefit. This is in contrast to the incentives under fee-for-service, which critics say foster inefficient behavior because the more services physicians perform for Medicare patients the more they are paid.

Researchers examining the feasibility of adopting DRGs for physicians have raised serious questions, however, about the efficacy of reforming the physician payment system through this mechanism. For example, DHHS's own draft report to Congress, never released, concludes that "DRG based payment to physicians is inadvisable because it would be difficult to put in place, complex to administer, and unpredictable in its impact . . ."[1]

ASIM has reviewed the research that has been completed to date on the feasibility of DRGs. Based on the results of the research and ASIM's own assessment of the practical implications of physician DRGs, ASIM opposes the use of DRGs as the basis of payment for any physician specialty or service. While the Society certainly recognizes the need to consider alternative methods of determining payment for physician services -- and has made specific recommendations in this regard to Congress and the Administration -- paying for physician services on the basis of DRGs remains a largely untested system that could undermine the quality of care provided to Medicare patients. ASIM believes that the ultimate intent of the Administration's proposal is, in fact, to fold all physician services into DRGs notwithstanding the last minute "compromise" to restrict it to RAPs. ASIM's specific concerns are:

- Negative impact on quality of patient care and access to services;
- Lack of experience with per case reimbursement of physicians;
- Cost saving potential of physician DRGs may compromise patient care;
- Potential for increased beneficiary liability;
- Inability of MD-DRGs to account for variations in case mix severity;
- Mandatory assignment under physician DRGs.

Negative Impact on Quality of Patient Care and Access to Services

ASIM has serious concerns about the impact of physician DRGs on the quality of and access to care. Extending DRGs to physician services would align the financial incentives facing physicians too closely with those of hospitals, therefore compromising the physician's traditional role as patient advocate, and, in effect, dramatically altering the balance of power in the hospital. Under PPS, hospitals have financial incentives to limit the services provided to patients because they are paid a set amount per diagnosis. Physicians, however, do not currently face the same constraints, and as such can resist pressure from hospitals or peer review organizations to discharge patients prematurely or provide less than adequate care to their hospitalized Medicare patients. Several surveys by the American Medical Association (AMA), ASIM, the Senate Aging Committee, and others, have demonstrated that under the existing PPS program, some patients are being discharged prematurely. The General Accounting Office has reported to Congress that Medicare beneficiaries are being discharged from hospitals sicker and quicker.

Of the 246 internists responding to an ASIM survey on DRGs and patient care, almost half reported being pressured by their hospitals to discharge patients earlier than medically appropriate.[2] ASIM members continue to report other DRG-imposed pressures that affect their ability to provide optimal care to their patients. **If physicians are placed under the same financial incentives as hospitals, ASIM believes these problems are likely to be exacerbated.**

While several approaches for structuring physician payment under DRGs have been suggested, each, in ASIM's view, has significant drawbacks that could seriously undermine the quality of patient care.

Paying the attending physician. Under this approach, either the attending physician would be responsible for paying the bills of other physicians out of his or her payment, or the attending physician would be responsible for dividing the payment among the various physicians involved in the care of a patient. The former approach is analogous to that used by some health maintenance organizations (HMOs) which place the primary care physician or gatekeeper "at risk" for specialist and other services. Because of their potential to reduce or limit services to Medicare beneficiaries, these so-called physician incentive plans by hospitals and HMOs were prohibited under the Medicare Quality

Protection Act, enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1986. Passage of this legislation reflected Congress' concern that certain economic incentives were placing undue pressures on physicians to limit care.

ASIM believes that making the attending physician responsible for paying for the services provided by other physicians raises the same concerns Congress attempted to address in OBRA -- that the physician might skimp on necessary care. While most physicians would continue to provide the best quality of care possible, given the limited resources available, a prospectively determined "cap" on reimbursement for a given diagnosis may force physicians to reduce care (e.g., make a decision not to use costly -- but more effective -- forms of treatment). Patients with severe conditions might find that physicians are reluctant to treat them, since they may be undercompensated, unless the DRG classification system were adjusted to account for differences in severity of illness. The present system does not, and this criticism has led to recommendations for its refinement.

Quality of care might also be reduced if the attending physician, for financial reasons, chooses not to use the services of a consultant, even though it would be medically prudent to do so. This could deprive patients of needed services. It is also likely to increase health costs over the long term since appropriate and timely use of consultants often will result in a decision to begin a more effective form of treatment -- with a concurrent reduction in length of stay and more rapid recovery time.

In assessing the impact of physician DRGs on consultation practices, Lowenstein, et. al. highlight the benefits of consultation and caution against allowing cost considerations to supersede concerns for quality:

> "While earnestly pursuing the goal of efficiency, safeguards for quality and accessibility must not be forgotten. One component of good quality care may be the consultation. Although it cannot be stated unequivocally that consultations lead to improved patient care, a positive relationship seems to exist. In addition, consultations play a significant role in postgraduate medical training, and they facilitate dissemination of medical knowledge. Under the current charge-based system of reimbursement for physicians, primary and consultative care are freely interwoven, and today it is rare that a hospitalized patient receives all of his care from a single physician.[3]

Paying the hospital. Under this approach, payment would go to the hospital, which in turn would pay the physicians for the care they rendered. This strategy, like the previous one, also has serious drawbacks. DHHS's draft report on physician DRGs highlighted two:

- Many hospitals would find it difficult to establish cooperative payment relationships with physicians. Small hospitals in particular may lack the expertise necessary to negotiate such arrangements with physicians. The cooperation between hospitals and their medical staffs that has been crucial to hospitals' ability to cope with the challenges of PPS could be seriously undermined if payment were made to hospitals.

- Hospitals would be in the position of paying physicians to admit patients to the hospital and even of paying a premium for especially profitable admissions. This could seriously compromise the physician's role as advocate for the patient and might compromise patient care.

ASIM has grave concerns about any proposals that would mandate physician reimbursement through the hospital, as this raises potential conflict of interest problems. Paying a lump sum payment to hospitals, who in turn would pay physicians, compromises the physician's traditional role as patient advocate. Patient care is currently safeguarded because physicians are not dependent on hospitals for reimbursement but are paid by patients and third parties. Should a hospital make a decision that the physician believes would adversely affect patient care, the physician, in his or her role as patient advocate, can intervene and protect the right of the patient to quality care. A DRG system that pays hospitals a lump sum payment would alter this role because both parties -- physicians and hospitals -- would benefit financially from providing only the minimal amount of care and services.

Hospitals may also have financial incentives to pressure physicians to discharge patients earlier than medically appropriate. There are indications that this is happening under the hospital prospective payment system. As reported by internists responding to ASIM's survey on the impact of DRGs on patient care:

> "Printed forms appear on the chart 1-2 days before the DRG expires strongly suggesting discharge."
>
> "The overall thrust of communications from the (hospital) administration is towards early, perhaps inappropriate, discharge."
>
> "When the DRG expires I am reminded and urged to do something."
>
> "Pressure to discharge sooner is very great and workup is often incomplete."

Many internists reported receiving daily updates or notices on how much their hospitals were losing as a result of certain patients. There were also indications that these pressures are being communicated to patients. As one internist commented:

> "One local hospital details the cost on the front of the record--the patient is aware of this. It has created anxiety."

ASIM believes that these pressures will only increase if the DRG payment is made to the hospital on behalf of physicians.

Paying the medical staff. This is viewed by some researchers as the most attractive option and the most feasible solution to the "who to pay" problem because of the ability to pool the risk among members of the medical staff. ASIM believes, however, that while this approach may minimize the individual physician's risk, it still creates problems that may negatively affect patient care. For example, as Jencks et. al. have pointed out:

> "Although the overall reimbursement of the medical staff may remain fair because of risk pooling, certain physicians, certain types of specialists, and certain specialty centers will cost the rest of the medical staff money, because the cases they treat involve inherently higher costs than the average calculated under the DRG system. An outlier policy might resolve this problem, but if it did not, these physicians and centers could become unwelcome.[4]

Other difficulties with this approach were cited in DHHS's draft report, which acknowledges that "the process of actually making such pooled payments would require major and untested changes in Medicare and in the usual organization of medical practice."[5] If payment went to the medical staff, there would also be a serious problem regarding acceptance of assignment. Concern about possible increases in beneficiary liability if members of the medical staff remained free to balance bill their patients would probably lead to mandatory assignment -- an approach the Administration and the medical community opposes.

DHHS also noted that medical staffs are not organized as corporations and would have difficulty in distributing their members' earnings. Those with whom HCFA consulted doubted that all medical staffs could do so in the short term. ASIM is concerned that requiring the medical staff to function as a payment entity would dramatically redefine the traditional role of the medical staff, which is organized for the primary purpose of carrying out its responsibility for the quality of the professional services provided by its members.

Finally, DHHS acknowledged that if the medical staff received payment for care, it might share collective responsibility for malpractice committed by any member.

Inability of MD-DRGs to Account for Variations in Case Mix Severity

One of the major problems associated with physician DRGs is their inability to account for variations in case mix severity. For physician DRGs to be an equitable form of payment, they must operate under the same "averaging" principle as hospital DRGs, that is, some admissions should require more physicians' services and others should require less, but on balance each physician involved in treating the patient should be fairly compensated. Hospitals treat enough cases in each category so that, on average, the gains and losses on particular cases are expected to cancel out. Empirical research has shown, however, that the law of averages does not work for physician services.

Many physicians have small inpatient caseloads and may experience large losses because of random fluctuation in case mix severity.[6] For example, in an analysis of 1982 Medicare Part A and B claims in Michigan, New Jersey, North Carolina, and Washington, Janet Mitchell of the Center for Health Economics Research found that the average internist in these four states admits only 62 Medicare patients per year. The majority of internists account for only a handful of admissions, with over half of all Medicare inpatients admitted by only 10 per cent of the physicians. The analysis further indicated that on average primary physicians treat fewer than three cases in any given DRG category and fewer than 45 cases in all categories in the course of a year. Because of the small numbers of cases treated by physicians, there would be little opportunity for gains and losses under DRGs to balance each other out, placing the individual physician at considerable financial risk.

The research also demonstrated the inequitable impact of physician DRGs across certain specialties and between medical and surgical DRGs. General practitioners had net gains in virtually every DRG for which they admitted, whereas internists and cardiologists could be expected to lose in almost every DRG in which they treated. Mitchell also found that surgical DRGs were relatively homogeneous but that the physician related costs associated with medical DRGs varied dramatically.

Mitchell suggests that specialty differences among winning and losing physicians may occur because of unmeasured case-mix differences within DRGs.[7] The DRG classification system presently in use for hospital services has been criticized for not adequately taking into account within-DRG differences in severity of illness. Analyzing the impact of this deficiency on physician payment, Mitchell has stated:

> "The heart-failure DRG, for example, includes patients with all degrees of severity, with and without various complications. If general practitioners treated mainly mild, uncomplicated causes, and cardiologists cared for those who required monitoring in the intensive care unit, then the losses incurred by cardiologists would be inequitable and might discourage them from treating Medicare patients."[8]

ASIM believes that the lottery-like nature of a physician DRG system — where certain specialties are "winners" and other "losers" — raises serious questions about the practical application of DRGs to physician services. DRGs were developed for hospital use, not for physician services, and the research indicates that they are not a suitable measure of the physician services that are required to treat a given case. ASIM believes that other more equitable ways of "bundling" or "packaging" need to be explored before any particular mechanism such as physician DRGs is endorsed.

Lack of Experience With Per Case Reimbursement of Physicians

Another serious problem with the extension of DRGs to physicians' services is the lack of actual experience with such a system. The research discussed above was conducted using a retrospective analysis of Medicare claims, and at best is only a hypothetical projection of how a physician DRG system might actually work. Unlike Medicare's adoption of prospective payment for hospitals, which relied heavily on the results of New Jersey's experience with the DRG methodology for inpatient care, there is no practical experience with a comprehensive case based payment method, like DRGs, for physician services.

ASIM is aware of only one study that has attempted to test and evaluate the concept of reimbursing physicians for in-hospital medical care on a per case basis.[9] This experimental program was very limited in scope, involving only 61 physicians who volunteered to accept scheduled per case reimbursement allowances as payment in full for Pennsylvania Blue Cross/Blue Shield patients treated by them at any one of nine participating hospitals. Only care provided by the attending physician was affected by this program.

Although the study did not use the current DRG system for classifying cases, it is similar in concept to the DRG proposal in that it paid physicians a prospectively determined amount for services rendered to patients with a given diagnosis. The study found that such a payment mechanism has potential for reducing length of stay for hospital inpatients, but also suggested that the results of a per case reimbursement system were likely to vary considerably from hospital to hospital, and that resultant cost savings were uncertain. The study also concluded that such a reimbursement approach would not be suitable for handling all claims arising from many diagnoses, particularly given the variability in patient conditions and care requirements.

ASIM believes that despite its limited scope, the Pennsylvania Blue Cross/Blue Shield study raises important questions about the feasibility, desirability, and cost effectiveness of per case reimbursement systems -- questions that largely remain unanswered given that no further demonstration projects have been conducted since 1976. Even DHHS has admitted that the absence of actual demonstration projects to test the concept would undermine its ability to extend a DRG system to physicians. Its draft report to Congress concluded that "DRG-based physician payments are of uncertain value and would require extensive demonstrations simply in order to show administrative feasibility. Such a system could not be developed for implementation in the near future . . ."[10]

Cost Saving Potential of Physician DRGs May Compromise Patient Care

ASIM questions whether paying physicians on the basis of DRGs will save the Medicare program money without seriously compromising patient care. According to the Office of Technology Assessment's report, Payment for Physician Services, "There is no guarantee that payment for inpatient episodes of care would save money for the Medicare program, although expenditures per case might be more predictable."[11] Overall program expenditures might in fact rise if physicians chose to re-admit patients or shift services to another setting.

Advocates of physician DRGs claim that this approach will help contain costs by providing physicians with incentives to shorten hospital stays, reduce unnecessary services, and provide more care on an outpatient basis. Under the prospective payment system (PPS), hospitals have already experienced significant decreases in lengths-of-stay and rate of admissions, and there is reason to believe that the utilization controls inherent in PPS could be reaching the point of diminishing returns. Reductions in admissions and inpatient stays both slowed in 1986, while length of stay among patients ages 65 and over continued to decline, but at a slower rate.[12]

ASIM believes these figures demonstrate that there may not be much more "fat" left in the system; current PPS incentives for hospitals and physicians to control utilization appear to be having the desired effect. Therefore, physician DRGs can only be an effective strategy for reducing expenditures if they achieve savings at the expense of denying needed services.

The Prospective Payment Assessment Commission (PROPAC) suggests that "the leveling off of length of stay could signal that preadmission and post discharge services have been shifted to other sites as much as possible. It could also mean that patients who remain in the inpatient setting are the sickest and that the easiest cases are being treated outside the hospital."[13] As a result, ASIM believes any payment mechanism that simply duplicates the financial incentives already in place under PPS is likely to yield only marginal "additional" savings at best, unless payment for each DRG is ratcheted down to the point where the consequence of cost savings is deleterious to patient care. Moreover, the capacity of physician DRGs to reduce utilization of services by certain hospital-based physicians, particularly pathologists and anesthesiologists, is limited. DHHS's draft report acknowledges that:

> "Bundling may be less necessary for controlling physician inpatient costs than for controlling hospital costs. There is evidence that hospital prospective payment already provides a number of the desired incentives by inducing hospitals to control those physician services which have associated hospital costs. For example, decreases in hospital length of stay decrease the number of daily hospital visits and decreases in numbers of x-rays decrease radiologist bills for interpretation.

> Another limitation to the bundling strategy is that the majority of inpatient physician charges are for surgery and anesthesia, and the typical pattern for such services is one surgery and one anesthesia per admission. Bundling does not create an incentive to reduce the number of such services and or to substantially reduce their intensity. The more straightforward way to control these costs is either to pay less for the services, or even more effective, to avert unnecessary admissions; the latter approach is one goal of Medicare's system of Peer Review Organizations, but capitated systems have been effectively accomplishing this goal for years. Physician DRGs would only affect the inpatient portion of physician costs, which is growing less rapidly than outpatient services."[14]

ASIM believes that making a change in physician reimbursement of the magnitude that the Administration is considering is precipitous due to the lack of evidence that physician DRGs would produce significant budget savings without compromising patient care. The data show that physicians and hospitals have responded to the incentives under PPS to reduce unnecessary admissions and services and provide care, where possible, on an outpatient basis. ASIM is concerned that further pressure on physicians to decrease admissions, limit length of stay and reduce services may come at the expense of patient care.

Potential For Increased Beneficiary Liability

ASIM is also concerned that physician DRGs may result in increased costs for Medicare beneficiaries. Under PPS, the inpatient hospital deductible and daily coinsurance rates have risen considerably due to declines in length of stay that are largely attributable to PPS incentives. In addition, the shift of some services from inpatient hospital treatment to the outpatient setting may have increased beneficiary cost sharing.

Although Congress has limited future increases, beneficiaries are still paying a higher proportion of inpatient hospital payments per case than before PPS. In 1983, beneficiary deductible and coinsurance accounted for about 8.0 percent of payments to hospitals for inpatient services; the proportion for 1987 is 9.2 percent.[15] PROPAC has recommended that the proportion of inpatient hospital payments borne by Medicare beneficiaries be returned to its pre-PPS level.

ASIM believes that the impact of physician DRGs on beneficiaries' out-of-pocket liability needs to be carefully assessed. The extent to which individual beneficiaries are affected will depend on how the coinsurance is determined. If, for example, coinsurance is determined from the standard DRG payment, some beneficiaries would pay more than under a non-DRG system, others less. Determining coinsurance in this manner is likely to reduce beneficiaries' incentive to control costs, because the coinsurance would no longer reflect actual services. Making the beneficiary liable for coinsurance on an average approved charge is unfair to beneficiaries whose charges would have been lower than the average. In essence, those beneficiaries with less complicated cases would be subsidizing the more costly ones.

Mandatory Assignment Under Physician DRGs

Proponents of physician DRGs believe that assignment would probably have to be mandatory under a case based payment system for physicians. Otherwise, physicians might accept assignment on cases that promised to be low cost relative to the case payment, but refuse assignment on cases that were likely to be high cost, thereby leaving the beneficiary liable for charges above the DRG payment.

ASIM opposes mandatory assignment for physicians' services. The Society believes that patients can best be served under the Medicare program if physicians are allowed the option of accepting Medicare's approved amount as payment in full. Specifically, the individual assignment option has the following advantages:

- The individual assignment option protects the patient-physician relationship. Under mandated assignment, the patient-physician relationship would be altered because physicians would be working for the government, not the patient. Mandated assignment allows the government to determine not only the level of payment for a given service but also in what circumstances patients can freely contract with their physicians to obtain needed services. Under mandated assignment, patients would not have the freedom to

contribute to the cost of a service, since any payment above Medicare's "approved amount" could result in sanctions against the physician. As a result, if Medicare's "approved amount" is insufficient to cover the costs of providing a needed service, the physician and his or her patient no longer would have the ability to contract to provide that service at a fair and reasonable fee. As the government continues to reduce payment for Part B services, physicians and patients will increasingly be constrained in their freedom to choose the nature of the care provided to the patient.

- The individual assignment option works to the advantage of poorer Medicare beneficiaries. Since Medicare is not a welfare program, beneficiaries vary considerably according to their ability to pay. By collecting their full fee from wealthier patients, physicians can afford to accept assignment on poorer patients and provide care on a charitable basis to indigent non-Medicare patients. This spreading of the costs benefits those poorer beneficiaries, while it does not impose a hardship on well-off patients that are able and willing to pay their physician's actual charge. In many ways, the individual assignment option is roughly analogous to the progressive income tax: Those individuals that have higher incomes indirectly subsidize those who are less fortunate.

Mandatory assignment is also unnecessary due to the large percentage of claims that are taken on an assigned basis. Recent date from HCFA show that 69.5 percent of all physician charges in 1986 were on an assigned basis.

ASIM believes that the concerns identified above clearly demonstrate that physician DRGs are neither feasible nor desirable at this time, and could severely affect the quality of care provided to Medicare beneficiaries. The quality of care problems experienced by many beneficiaries under hospital prospective payment underscore the need for a more thorough evaluation of the effects of the current DRG system on patient care before any consideration of its application to physicians. Even if limited to certain hospital-based specialties such as radiologists, anesthesiologists, and pathologists, physician DRGs are likely to have several undesirable effects on the quality and availability of care provided to Medicare patients:

- They may encourage hospitals to decide, on the basis of price only, whom they wish to contract with to provide RAP services. This could especially be a problem if payment for RAPs comes out of the same pool of money that goes to the hospital. To the extent that the lowest cost radiology, pathology, and anesthesiology groups are not necessarily the "best," this would be detrimental to the quality of patient care provided to hospitalized Medicare patients.

- The hospital would have an incentive to decide when pathology and radiology services will be involved, and potentially to limit internists' access to needed pathology and radiology services. For example, an attending internist's ability to obtain needed x-rays for his or her patients may be jeopardized if there are hospital imposed pressures on radiologists to curtail the number of x-rays for payment purposes.

- MD-DRGs for RAPs could create an incentive for hospitals to reduce the number of anesthesiologists on the staff by replacing them with nurse anesthetists who could administer anesthesia under the supervision of fewer anesthesiologists. Instead of one anesthesiologist being available for each surgical procedure, there might instead be one anesthesiologist supervising several nurse-anesthetists administering anesthesia during several concurrent operations. This would undermine quality of care and place more liability on the hospital, surgeon and internist involved in treating each patient.

- Under DRGs, hospital-based physicians would have incentives to shift their services to ambulatory settings. Radiologists might engage in ambulatory work and anesthesiologists might choose to work in ambulatory surgery centers. In addition to affecting quality of care, the change in sites might reduce access to those physicians for hospitalized patients.

Recommendations

1. Congress should refrain from enacting major changes in the Medicare physician payment system, such as the Administration's proposal to begin paying for physician services on the basis of DRGs, until a resource cost relative value

scale (RVS) is developed. Once a resource cost RVS is available, Congress will for the first time have a logical, rational basis for determining levels of payment under the Medicare program in a way that is far more predictable and understandable for beneficiaries and physicians, without the potential adverse impact on quality and availability of care associated with MD-DRGs.

ASIM believes that the customary, prevailing and reasonable (CPR) methodology must be replaced by a new system of payment, consisting of a schedule of allowances based on a resource cost relative value scale. A resource cost RVS would help accomplish two important health policy goals: altering incentives for high cost technology and protecting patients from overutilization of services. Under the CPR system, an irrational system has evolved that is having a negative influence on the care Americans receive today. Distortions in the relative valuations of cognitive and procedural services have created financial disincentives and likely contribute to the public perception that medicine today is too costly, inefficient, and impersonal.

As a result of these distortions, a physician who orders or performs an expensive array of technology-intensive services is well compensated. A physician who spends time with a patient, carefully assessing his or her need for further tests and procedures, is penalized.

A resource cost system--by placing more reward on time consuming, complex "cognitive services" in comparison to technical procedures--would be a major step toward reducing such incentives for overutilization of high-cost technology.

Congress has already demonstrated its support for a resource cost RVS. The Consolidated Omnibus Budget Reconciliation Act of 1985 requires the Secretary of the Department of Health and Human Services, taking into account a thorough examination of input costs for physician services, to report by July 1, 1989, on the development of an RVS for implementation in 1990.

2. Physicians and payors should explore equitable, fair and appropriate ways of "bundling" or "packaging" services to minimize the fragmentation of billed services that may occur under the existing "a la carte" billing and coding system. More research and discussion must take place, however, before any particular scheme is endorsed on the most appropriate way to "package" or "bundle" services. The Omnibus Budget Reconciliation Act of 1986 directed the Secretary of HHS to study the potential for reducing the number of codes used by carriers for payment purposes. The Physician Payment Review Commission has recommended that the definition of codes for medical and surgical services, including standardization of services covered by global fees for surgery, should be refined and standardized. The Commission will be convening an expert panel to make recommendations for change.

ASIM believes that it is prudent for Congress to wait until the results of this research are available before endorsing any particular method of packaging physician services, such as physician DRGs.

ENDNOTES

1. "Paying Physicians: Choices for Medicare." Washington, D.C., Department of Health and Human Services, Unpublished draft report. 1986.

2. American Society of Internal Medicine. "The Impact of DRGs on Patient Care." Washington, D.C., October 1985.

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STATEMENT OF THE MEDICAL GROUP MANAGEMENT ASSOCIATION

MGMA POSITION STATEMENT ON THE RAPS ISSUE

The Medical Group Management Association (MGMA) appreciates the opportunity to present these views on the Reagan Administration's proposal to pay for certain physician services on the basis of the DRG, prospective payment system. MGMA is the nation's oldest and largest professional association of medical group practices, representing nearly 3,300 medical groups in which approximately 70,000 physicians practice their profession.

MGMA member groups represent the broad spectrum of medical organizations in the United States, including large multispecialty clinics that draw patients in need of sophisticated tertiary care from throughout the world to small single specialty group practices serving a local medical market. Some member groups operate exclusively on a fee-for-service basis, others are entirely prepaid, and many combine elements of both prepaid and fee-for-service practice. Many are free-standing physician practices, but a growing number are affiliated with hospitals, medical schools, or health maintenance organizations, and in some cases they combine all three. Some own their own hospitals and/or HMOs and serve as the centerpieces of emerging integrated healthcare systems.

A sizeable portion of the MGMA membership would be directly affected by any significant legislative change to Medicare's method of paying for physician services, including the services of radiologists, anesthesiologists and pathologists (RAPs) and the supporting personnel who practice with these physicians. More specifically, MGMA represents approximately 150 single specialty groups in radiology, 74 in anesthesiology, and 44 in pathology, plus 834 multispecialty group practices which contain one or more physicians practicing in these three specialties. Even medical groups with none of these three specialties would be affected by the RAPs proposal, since they often interact daily with anesthesiologists, radiologists, and pathologists.

THE RAPS PROPOSAL

The Reagan Administration budget proposes to incorporate Medicare payments for the services of radiologists, anesthesiologists, and pathologists into the DRG prospective payment system where services are rendered to hospital inpatients. Such a proposal would represent a drastic departure from the way in which physician services are now paid for under the Medicare program.

If enacted, this proposal could have potentially serious adverse implications for the quality of care received by Medicare beneficiaries. Specific problems could arise in such areas as the entitlement of beneficiaries to coverage for all physician services deemed "reasonable and necessary" to quality treatment; "freedom of choice" with respect to the site in which patient care would be delivered, particularly in rural areas; the relationship between physicians and hospitals; and the relationship between physicians in the RAPs specialties and other members of the medical community.

THE RAPS PROPOSAL RELATED TO OVERALL PHYSICIAN PAYMENT REFORM

The Administration's RAPs proposal should be viewed not in isolation, but in the context of the Congress' much broader review of Medicare physician payment issues generally. MGMA has previously communicated to the Congress several broad criteria against which various Part B reform initiatives should be measured. First, if the participating physician program is to continue in Medicare, it should remain voluntary. Mandatory assignment would unnecessarily restrict both patients' and physicians' choice, could diminish patient access to care, and would unfairly penalize physicians when the federal government does not recognize a fair professional fee. Second, our members believe any system for paying physicians under Medicare should remain pluralistic. Significant reforms should expand the range of options available to both physicians and patients, not limit them. Third, possible Part B changes should be debated on the basis of policy, not just budget. And fourth, any significant changes should be undertaken with adequate lead time for careful design, demonstration, evaluation, modification and subsequent implementation.

The Administration's RAPs proposal does not measure up to any of these broad criteria. By putting hospitals in a position to broker physician services, it could well limit organizational and delivery arrangements which now afford both physicians and patients considerable flexibility. By treating payment to the hospital as payment in full, it further undercuts the traditional Medicare principle that physicians should be able to charge a fair price for their professional services, and that patients should be able to choose among physicians using a variety of criteria of their own choosing, only one of which may be price. While this principle has already been substantially eroded by the Medicare fee freeze and subsequent "OBRA" price control systems, the RAPs proposal is different in kind. Patient access would be limited to only those physicians willing to provide services under some sort of contractual agreement with a hospital.

The RAPs proposal also represents a clear example of how federal budgetary considerations rather than policy are guiding Medicare payment reform. HCFA's professional staff did not initially recommend this proposal to the Office of Management and Budget, nor did Secretary Bowen recommend it to the President. Instead, the RAPs proposal emerged after the Office of Management and Budget initiated a proposal to pay for all inpatient physician services through the DRG system, as part of a grand scheme to produce multibillion dollar budget savings. It then retreated from that position to this less extensive, but equally tenuous budget-driven compromise. No careful design work preceded the OMB proposal, and no demonstration of the feasibility of the RAPs concept is contemplated, with immediate implementation now proposed for the purposes of immediate budget savings.

SPECIFIC PROBLEMS WITH THE RAPS PROPOSAL

1. Problems Created for Hospital and Physician Relationships -- The Fallacy of the "Hospital-Based" Physician

One argument advanced in favor of the RAPs proposal is that since radiologists, anesthesiologists and pathologists are already "hospital-based," payment for their services could easily be folded into DRG payments to hospitals. This argument is faulty, since it is based on erroneous ideas about how these three specialties now practice and how they are legally structured.

It is true that all acute care hospitals have some capabilities in radiology, pathology and anesthesiology. It is not true, however, that all RAPs are "based" in hospitals, or even conduct a majority of their practice there. Similarly, many RAP services provided in the hospital setting are provided to hospital outpatients, not to inpatients covered under the DRG system. An increasing number of services are now also provided in office or other ambulatory facilities.

Another problem with the term "hospital-based" is that even where physicians conduct a substantial portion of their practice at the hospital, their economic and organizational affiliation is not with that hospital but rather with a physician partnership or professional corporation (i.e., they are paid by the partnership or professional corporation). In large multispecialty group practices organized in this way, diagnosis and treatment decisions are often made collaboratively by several specialists within the group. Business transactions related to services provided in hospitals by these physicians would also be handled by these entities rather than the hospital.

A proposal to interpose the hospital as a broker of RAPs services could, therefore, be potentially disruptive to both existing treatment and business relationships. For example, in a hospital now served by RAPs from several group practices, the hospital might bargain for an exclusive contract. Thus, surgeons in the other multispecialty groups would no longer be able to work with anesthesiologists from their own group and might have to send pathology work to a second group and radiology to still a third. This also could jeopardize the coordinative/case management function now being performed by the group, which enhances the quality of patient care by allowing for prompt diagnosis and treatment in a more cost effective manner.

2. Negative Implications for Patient Access to Services

Many RAP specialists now serve patients in more than one hospital. In some rural areas, RAP specialists may be virtual "circuit riders," travelling to remote institutions not needing full-time coverage by these three specialties. The "average" resources available to rural hospitals under the proposal likely will not be adequate to entice physicians to continue "circuit riding." Further, because many of these same rural hospitals often face financial difficulty, they would not be in a position to offer attractive financial incentives to physicians using funds from some other source in order to subsidize losses from the RAP DRGs.

Another easily anticipated problem is that hospitals will find ways to "skim" those patients whose needs, on average, for RAPs services are less than the amounts incorporated into the DRG rates.* The existing DRG program has already been criticized for not being sufficiently sensitive to the differing intensity of service needs within DRG classifications.

3. Negative Implications for the Quality of Patient Care

Part B of the Medicare program covers those physician services which are "reasonable and necessary" for the diagnosis and proper treatment of patients. Historically, physicians have determined what types and intensity of service are "reasonable and necessary" after assessing the needs of individual patients. Treatment determinations have been made either directly in the context of the physician-patient relationship or indirectly, as physician-to-physician consultation and referral have taken place. Utilization review and quality assessment by PSROs and now PROs have also been important in maintaining the balance between cost control and quality assurance. This system has served the patient well by giving physicians professional discretion in determining what is best for their patients.

By putting hospitals in a position to pay physicians for all inpatient RAPs services, as proposed by the Reagan Administration, this careful balance would be altered. Hospital administrators would suddenly have a direct financial incentive to intervene directly in judgments about what levels of care are "reasonable and necessary" for patients. This interference could take many forms. Fewer tests would be ordered, even where further diagnostic work might affect treatment decisions. Attending physicians would be more inclined to rely on their own interpretations of laboratory or imaging results, rather than consulting with specialists. Similarly, general surgeons would be asked to supervise CRNAs in more complicated cases without anesthesiologist involvement.

It is ironic that the Administration should propose such a system at the same time the Congress is demonstrating great concern over problems posed under the DRG system by hospitals offering incentives to physicians to underserve patients. The discharge of patients "sicker and quicker" amply demonstrates how even subtle changes in financial incentives and day-to-day control can affect the delivery of medical care.** Under P.L. 99-509 (OBRA), Section 9313(c), Congress recognized the potential harm resulting from relationships between hospitals and physicians where the physician has an incentive to undertreat. The damage to patients would be no less real simply because hospitals, rather than physicians, were provided with incentives to minimize costs, as would be true under the proposed RAPs system.

* Physician Reimbursement Under Medicare. Congressional Research Services. December 3, 1985, page 37.

** Physician Incentive Payments by Hospitals Could Lead to Abuse. GAO/HRD-86-103.

4. Lack of Research or Demonstration Experience to Support the RAPs Concept

Congress and the Administration have been reviewing the question of changing Medicare's Part B payment system for physician services since 1983, when the Social Security Amendments instituting the PPS system under Part A asked the Secretary of Health and Human Services (DHHS) to investigate the advisability and feasibility of incorporating physicians into the DRG payment system. Since that time, analyses and recommendations have been made by DHHS, the Office of Technology Assessment, the Congressional Research Service, the GAO, and several Congressional committees. A Physician Payment Review Commission was also recently chartered by Congress to assist with this task, and a study of the feasibility of a resource-based relative value scale is still in progress.

Oddly, though virtually every one of these bodies has discussed the concept of physician DRGs generally or RAPs specifically, not one has produced a concrete proposal to implement physician DRGs even for RAPs, nor has a recommendation that Congress should proceed to amend Part B in that fashion been made at this time. Those that have looked most closely at the viability of implementing physician DRGs have all pointed to the need for additional research and demonstrations to determine whether the concept has long-term merit. Because of the virtually unanimous judgment of the policy community that RAPs, even if they have potential merit, are not yet ready for implementation, we believe it is ill-advised for Congress to adopt a hastily drawn proposal forced on the Department by the Office of Management and Budget solely for budgetary reasons.

In conclusion, we urge members of Congress and the Reagan Administration not to proceed with any RAPs proposal until there has been ample opportunity to carefully consider the results of the physician payment reform studies only recently commissioned by Congress and until there has been an opportunity for careful review by the Physician Payment Review Commission. The members of the Medical Group Management Association favor a coordinated and well-planned approach to Medicare payment reform. We would welcome the opportunity to review the details of any RAPs proposal with both the Administration and Congress in order to facilitate Medicare payment reforms which minimize business difficulties for medical groups, while at the same time enhance the delivery of quality care to Medicare patients.

STATEMENT OF

FORMER CONGRESSMAN JAMES ROOSEVELT

CHAIRMAN OF THE

NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Mr. Chairman, I am James Roosevelt, chairman of the National Committee to Preserve Social Security and Medicare. I represent over four million Americans, most of whom are Medicare beneficiaries. Our members are concerned, as you are, at the rising cost of medical care which comes out of their pockets as well as out of Medicare. Consequently, the National Committee strongly supports doctor fee reform along with mandatory assignment as long as fee reform does not undermine the quality of medical care.

This Subcommittee is considering an Administration proposal which will reform doctor fees for radiologists, anesthesiologists and pathologists who are hospital-based physicians by including their fees in the hospital Diagnostic Related Group (DRG) payment system. Unfortunately, the Administration proposal, which it hopes to eventually extend to doctor fees for all hospital services, would jeopardize the quality of hospital care. For that reason, the National Committee opposes it.

Since DRG-based payments to hospitals were initiated, average hospital stays have been shortened by a little more than two days and some patients have reportedly been discharged "quicker and sicker." The role of doctors is to prevent premature release from hospitals and assure that patients receive a full range of necessary medical services. If radiologists, anesthesiologists and pathologists are placed under a DRG-based payment system, they will no longer function as patient advocates. Economics will force them to align themselves with hospital administrations to reduce the scope and intensity of services provided in order to maximize profit. In the process, seniors will be at risk of being shut off from the newest, most sophisticated diagnostic and therapeutic instruments.

While we oppose the specific reform proposed by the Administration, we urge the Congress to enact mandatory assignment without waiting for fee reform. Representative Brian Donnelly recently introduced such a bill, H. R. 1923. Mandatory assignment protects beneficiaries from excess charges and may also be necessary to force doctors to negotiate with Congress a fair fee system. The arguments in favor of mandatory assignment, while relevant to all doctors, are particularly relevant to hospital-based physicians and other specialists.

As you emphasized in the press release announcing this hearing, Mr. Chairman, patients often have very little if any choice, especially in selecting hospital-based physicians. It is not just exclusive individual or group contracts which limit patient choice, though that certainly is an important factor. A patient confronted with an emergency is in no position to bargain hunt for a physician. Medical needs do not always signal themselves far enough in advance to permit comparison shopping either for price or reputation.

One of our members described the problem well. He wrote that their own physician was a participating physician, but that was no help when his wife was hospitalized and specialists were needed. "She was too sick to even lift up her head. I couldn't be there full time. Was she supposed to ask everyone who came in the room if they would accept the Medicare payment? And what could we have done if we had known they would refuse?"

The current method of paying for all physician services perpetuates a system where the ability of a Medicare beneficiary to find a physician who will accept the Medicare approved fee varies by specialty and by geography. Arguments can be made that mandatory assignment with its statutory limit on the ability of physicians to overcharge is most urgently needed for hospital-based specialists because patients truly have no choice. We believe,however, that all patients need protection against overcharging and recommend mandatory assignment in all cases.

Thank you.

POSITION PAPER
ON
PHYSICIAN REIMBURSEMENT FOR
MEDICARE PATIENT CARE
by the
PATHOLOGY PRACTICE ASSOCIATION

INTRODUCTION

The PPA is a national, non-profit organization composed of pathologists practicing in hospitals and independent laboratories throughout the country. It was formed six years ago to advance a better public understanding of the practice of pathology. It is the PPA's philosophy that an ongoing education program aimed at government policy makers and the public at large will foster a clearer understanding of how pathologists, particularly those in private practice, contribute to health care, and will result in policy decisions on federal health care expenditures that will better serve patients.

The Pathology Practice Association understands and appreciates the difficult decisions facing Congress. There is indeed a compelling need to find federal savings to reduce the general fund deficit, while at the same time there is an inherent responsibility to ensure that beneficiaries of our federal health care system are guaranteed access to services that they deserve and have been promised.

This position paper represents the results of a workshop involving pathology representatives of major national organizations. This group convened in Dallas in 1984 and was composed of private, academic and hospital-based pathologists. This document has been subsequently updated to refelct the current debate concerning physician payment reform.

Physician Reimbursement for Part B Medicare Services -- A History of Cost Containment

Since Medicare's inception, the federal government has used legislation, regulation, and administrative guidelines to curb Part B cost increases and exert controls over physician payment. From the late 1960s through the 1970s, charge limits were frozen and unfrozen, charges were updated with increasing frequency, and fees were made subject to the Medicare Economic Index (based on inflation in the overall economy and changes in office practice costs) as a cap or ceiling on prevailing charges.

By 1980, most hospital-based physicians -- including pathologists -- were reimbursed for Part B Medicare services on the basis of a combined billing. These arrangements provided that billings for clinical and anatomic laboratory services be combined and that payments be made on a percentage basis. The arrangement worked well for all parties. There appeared to be no reason to adjust upward prevailing charge levels for anatomic services since much of the pathologists' income was derived from clinical laboratory services.

The Tax Equity and Fiscal Responsibility Act enacted in the summer of 1982 changed all that. Clinical pathology, by and large, was classified as Part A reimbursable, combined billing was eliminated, and pathologists were forced to bill directly for their anatomic Part B services. Medicare carriers were required to construct new anatomic prevailing rates to accommodate the direct billing requirement. As carriers began to compile this data in 1983, the Deficit Reduction Act was enacted and physician fees were frozen. This forced carriers to go back five-to-ten years in some cases to find reliable charge data. As a consequence, rates were set in many areas of the country far below what could

ever be considered realistic and equitable. The act also inaugurated a Diagnostic-Related Group (DRG) payment system for the hospital's share of the Medicare bill.

In 1984, Congress introduced the concept of "participating physicians" to identify those physicians willing to take assignment of Medicare patients. This change in nomenclature was accompanied by a 15-month freeze on customary and prevailing charges for all physicians and a freeze on the charges submitted by non-participating physicians. To encourage assignment, the freeze was structured to fall more heavily on non-participating physicians.

Enactment of the Gramm-Rudman Balanced Budget & Emergency Deficit Control Act in 1985 imposed an across-the-board cut in Medicare fees of at least one percent. In addition, the physician fee freeze was extended through March 14, 1986. However, later that same year Congress passed COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). This law extended the freeze through 1986, but lifted it for participating physicians effective May 1, 1986.

In October of 1986, Congress approved physician Part B Medicare reimbursement reforms which established a permanent four percent payment differential between participating and non-participating physicians. Under the current law, non-participating physicians cannot charge more then the "maximum allowable actual charge" (MAAC). Congress also endorsed the "inherently reasonable" charge controls used by HCFA and ordered the agency to review the ten most costly procedures paid for under Part B Medicare physician reimbursement that are the most likely prospects for such controls.

DRGs For Hospital-Based RAPs

Until this year, the Reagan Administration favored moving physician reimbursement toward a capitation payment system. Under this approach, Medicare pays an organization, either a provider or insurance company, a set monthly fee (or capitation amount) for both Part A and Part B for each beneficiary covered. Since 1982, HCFA has sponsored other demonstration projects with state and local governments. Therefore, it came as a shock to many in the medical community when the Administration announced its endorsement of an OMB proposal to create a DRG payment scheme for all hospital-based physicians as part of its fiscal 1988 budget plan. This represented a major policy shift.

Shortly following its announcement, the proposal was amended to placate the objections of high-ranking administration health officials. The amended proposal has been scaled down to target only three groups of hospital-based specialties: radiologists, anesthesiologists and pathologists (RAPs). However, the effort is still viewed by many as the first step toward a DRG system for all Medicare physician services.

The PPA is strongly opposed to the DRG for RAPs proposal. Pathologists resent being among the physician specialties singled out for this treatment -- particularly in light of their excellent rate of acceptance of Medicare patients and assignments. The PPA urges Congress to consider the following in its deliberation of extending DRGs to hospital-based physicians.

- Lack of Information and Experience: To our knowledge, there are no comprehensive data available on the applicability of extending DRGs to physicians, and only one study has attempted to test and evaluate the concept of reimbursing inpatient medical care on a per-case basis. That study was conducted nine years ago by Pennsylvania Blue Shield and involved a number of physicians who agreed to accept reimbursement on a

per-case basis at any one of nine participating hospitals.

The DRG for RAPs proposal jumps the gun on a HCFA feasibility study which is not expected to be completed until mid-1987. In that report, HCFA has already criticized the proposal. In part, the unpublished report stated that, "DRG-based physician payments are of uncertain value and would require extensive demonstrations simply in order to show administrative feasibility." A draft copy of a Health and Human Services report, Paying Physicians: Choices for Medicare which was due in 1985 but returned to HCFA by the Office of Management and Budget for a revision, was also critical of the DRG for RAPs approach. The report noted that most inpatient physician charges are for surgery and anesthesia and that "bundling does not create an incentive to reduce the number of such services."

In addition, two major reports are due within the next 12 months which will shed additional light on the feasibility of DRGs: a Harvard study concerning the merits of relative value scales and a comprehensive analysis by the Physician Payment Review Commission (PhysPRC) created by Congress.

We would urge Congress and the Administration to move cautiously on a physician DRG approach to reimbursement and we would urge the development first of one or more demonstration projects to determine: 1) the extent of federal cost savings, if any, and the impact of the inpatient payment scheme on outpatient services; 2) the impact on the quality of patient care; 3) the impact on the availability of services and technology; 4) the impact on hospitals and other non-physician providers such as skilled nursing

facilities, psychiatric facilities, home health care, etc.; and 5) the extent of acceptance by various physician specialties.

- Physician DRGs Could Have a Deleterious Effect on the Quality and Cost of Care: Reimbursing physicians a predetermined amount for the treatment of patients would create disincentives for them to spend significant and necessary amounts of time on patient care. The PPA concurs with a statement on the potentially adverse impact on the quality of care as presented in a position paper on DRGs prepared in 1984 by the American Society of Internal Medicine. The paper stated in part:

> "This type of system also creates economic incentives for physicians to skimp on care. While most physicians would continue to provide the best quality care possible given the limited resources available, a prospectively determined "cap" on reimbursement for a given diagnosis may force physicians to discharge patients earlier than is optimal, decrease necessary visits, and/or make decisions not to use costly -- but more effective -- forms of treatment. This is particularly likely for older and sicker patients for whom the DRG payment is likely to be lower than the actual resources required."

Beyond this and in a more specific sense, it is likely that primary care physicians would decrease their use of physician consultants and attendant ancillary services that are critical for comprehensive patient care. This could have significant medical consequences for the beneficiaries, and would not be cost-effective.

The PPA also believes that any DRG payment mechanism applied to physicians should recognize that medical technology is a necessary component of comprehensive, quality patient care. A DRG system would not have the flexibility to provide for necessary advancements in medical technology and procedures.

- Pathologists and Other Hospital-Based Physicians Should be Separated From Any Overall DRG Payment System for Physicians: To the extent that providers control utilization of services, hospital and physician cost containment concerns have and should rightfully center on those who initiate care. Medicare Part A (hospital costs), according to data compiled by the Senate Committee on Aging, is the second largest federal program after Social Security. Three quarters of the Part B costs are for direct doctor services, the remaining one-fourth are for services ordered by physicians and performed mostly by physician consultants, including pathologists, radiologists, cardiologists, etc. Under current Medicare reimbursement mechanisms, all physicians, except those who are hospital-based, provide whatever services they deem necessary to treat the patient properly and are paid based on usual, customary and reasonable payment rates. Hospital-based physicians, including pathologists, act as consultants to these primary care clinicians and perform work for patients as ordered. With rare exceptions, pathologists do not initiate tests or control to any degree of frequency the application of laboratory technology. Therefore, a DRG cost containment mechanism should be applied differently to those physicians who do not initiate care, such as hospital-based pathologists.

- DRG Payment Should Be Paid Directly to Those Who Provide the Service and Not Through the Hospital or the Primary Care Physician: Any proposal which requires that DRG reimbursement be made to and allocated by the hospital or the primary care physician compromises the individual physician's traditional role as an advocate for the patient and disrupts the implied contract between the doctor and the patient. Patients already are feeling the effects

of changes in hospital reimbursement under prospective payment. Some hospitals are retaining Part A payment for pathology services, and consequently in those hospitals these services may not be provided at the same level of intensity -- even though funds have already been disbursed for those services. When hospital and physician reimbursement are separated, as under the current reimbursement system, patient care is safeguarded because physicians are not dependent upon the hospital or other group providers for payment for services. A DRG system that pays hospitals a single lump sum for all medical care would dramatically alter the doctor/patient relationship. The incentive of the primary care physician would be to maximize reimbursement, and yet again, no program savings would accrue. A DRG system that pays consultants through the primary care physician would have the effect of decreasing use of those consultants who are so critical to comprehensive patient care. The only way to preserve quality care is to ensure that payment for services is made directly to those who provide the services.

Evaluation -- Negotiated Fixed Fee Schedules for Physicians

It has been suggested that fixed-fee schedules for physicians be considered as a method of payment reform. The PPA has the following concerns over this payment mechanism:

- Any Fixed-Fee Schedule Payment System Must be Constructed Carefully and Equitably: The major consideration in the design of a fixed-fee schedule is the initial level at which fees are established. Some government officials have suggested that the total costs generated by any fee schedule should not exceed that which would have been paid under the current system. This would mean, however, that some

physicians would have to accept a reduction in recognized fees. The PPA believes that any fee schedule should be set at the upper ranges of current distribution and be based on a relative value scale; that a mechanism be established for equitable fee schedule adjustments, and, moreover, that accurate and realistic prevailing rates must first be set by the carriers.

- o Any Fixed-Fee Schedule Must Preserve the Concept of Direct Payment: As stated in the section on physician DRGs, any reimbursement mechanism that does not provide direct payment to the physician performing the service compromises the quality of patient care and destroys the role of the physician as patient advocate. A physician fee schedule which allocates a single sum to hospitals or any other group provider would compromise the doctor/patient relationship. The incentive of the primary care physician would be to maximize reimbursement, and yet again, no program savings would accrue. And a fee schedule that pays consultants through the hospital or primary care physician would have the effect of decreasing use of those consultants who are so critical to comprehensive patient care.

- o Mandatory Assignment Attached to a Fixed-Fee Schedule Might be Supported by Pathologists Under Certain Conditions: Recognizing the constraints on the Medicare program, pathologists could support mandatory assignment of Medicare payment: if (and only if) three conditions were met: 1) that HCFA conduct a study in conjunction with organized medicine to determine accurate and fair prevailing rates nationwide with emphasis given to urban and rural wage differentials and other factors; 2) that HCFA abandon

individual physician profiles, which tend to produce inequities, and 3) that Congress enact technical correcting language to current DRG legislation to provide that all Part A professional services rendered by pathologists be passed through to the pathologists and not retained by the hospital.

- A Fee Schedule Must Recognize Part B Payment for Autopsies: Autopsies serve as one of the most important forms of quality control in patient care, ensuring accuracy of diagnoses. They are also a far more accurate tool for measuring appropriate medical utilization than the expensive Peer Review Organizations. Autopsies also play a critical role in medical research by evaluating the accuracy of new forms of medical treatment and diagnostic techniques. Yet, this long-standing professional service is not recognized as such under current Medicare reimbursement provisions. The PPA believes that if a fixed-fee schedule is established, rates commensurate with the time and skill required to perform an autopsy must be established and paid under Part B, or the Part A reimbursement now given to the hospital must be passed through to the pathologist.

WRITTEN COMMENT ON ISSUES RELATING TO PAYMENT OF PATHOLOGISTS ON THE BASIS OF DIAGNOSIS RELATED GROUPS BY LIONELLE D. WELLS, MD.

I, Lionelle D. Wells, M.D. am a pathologist in private practice in Evansville, Indiana. I am submitting these comments as a private individual. I am representing no organization. I have an interest in the welfare of patients and in the continuing advancement of our health care system.

I believe that the current methods of payment for hospital based physicians, in particular pathologists, are anticompetitive and should be altered. My proposal is that hospital based physicians protected by exclusive services or exclusive use contracts should be required to accept assignment and that these fees should be paid directly to the hospital along with the DRG payment for distribution to the physicians. Those hospital based physicians not covered by exclusive contracts, and facing real competition from another group providing similar services at their facilities, should be compensated in a manner similar to other practicing physicians, i.e. through direct patient billing under Medicare Part B.

Forcing hospital based physicians with an exclusive contract to accept assignment and receive payment from the hospital would force the hospitals to assume financial risk for any services provided under an exclusive contract. This would result in reduced expenditures for hospital based physicians services provided under an exclusive contract. I believe that most physicians would seek a non-exclusive arrangement in such an enviroment, and that the resulting direct competition between physician groups would hold down prices for services billed under Medicare Part B. Forcing all hospital based physicians to accept assignment will only result in continued cost-shifting to other individuals or an eventual deterioration in the quality of hospital based physician services.

Currently, a hospital has an interest in making the services of anesthesiologists, radiologists and pathologists available to the other members of its medical staff (in particular surgeons) in an orderly and convenient manner. In order to accomplish these objectives, and to provide for the medical administrative services in the hospital based physician departments, a hospital generally grants a single, or small group, of individuals an "exclusive" contract to perform services in these specialty areas. These contracts prevent other qualified individuals from performing these services for patients and/or members of the medical staff at the institution granting the contract.

An exclusive service contract is a great advantage to the hospital because there is no financial risk, and the hospital derives great benefits. A typical contract will require the hospital based physician to bill patients for the services performed for patients at the request of the attending physician. The most profitable hospitals will generally make only a token payment to the contract physician for administrative services. Therefore the hospital has only to provide a steady stream of patients, and the contract physicians are guaranteed a substantial income.

Providing such services under contract makes a facility easier for members of the medical staff to use, and the hospital therefore will increase its utilization of high-margin surgical services with no risk, and no expenditure of operating funds. The expenditure of capital may often be minimized as well through a joint-venture, exclusive contract arrangement. This sounds ideal until one realizes that the individuals and/or organizations ultimately paying the bill have had no opportunity to influence the selection of the individuals or organization providing the contract services. The end result is that the hospital and the

contract physicians seek to supply the best possible services to the members of the medical staff (not the patient, although what is good for the medical staff is generally good for the patient) and one then bills the patient and/or other third party to recover the costs of the services provided.

The third party payment mechanism has therefore been forced to subsidize the costs of a generally very high level of service and expertise among hospital based physicians where such services may not be necessary. Not all hospitals and not all patients require the highest level of expertise in all cases, yet in order to guarantee the availability of such services when deemed necessary by a member of the medical staff, the contract group must maintain a cadre of physicians with all required skills at whatever cost to the remaining patients, and such cost is substantial.

For example, in pathology, most surgical cases do not require a frozen section or gross consultation during the actual surgical procedure. However, a surgeon prefers to operate in a hospital where such services are available on short notice. The payment for such consultative services is very poor, therefore, the hospital grants a provider group an exclusive contract including explicit instructions that such services will be provided to surgeons on their request. The pathology group will therefore arrange to have a member of the group available in the hospital during all times that surgery is performed routinely and available on short notice at all other times. The costs of having a highly trained individual available for rapid consultations is substantial, and as a result all hospital patients are billed at a high rate for all pathology services performed.

Often a hospital based pathology group will also perform pathology services for an outpatient surgical center or for a physicians office practice at a price substantially lower than for inpatients. In many cases the type of work performed and the consultation report issued are identical to that done for hospital patients, yet such services may be done for one-third to one-quarter of the price charged for hospital inpatients. The reason is that all hospital inpatients are being charged for the fixed costs of maintaining highly qualified physicians in the hospital for the few patients that actually require intra-operative consultation, and the outpatients are only being charged the marginal costs of services provided to fill the excess time of the hospital based physician waiting in the hospital.

As you can see, an exclusive contract arrangement is beneficial to the hospital, and is grossly unfair to the majority of patients who do not require such services, but do pay for them. Moreover, the hospital can choose to provide such a level of service without incurring any financial risk, since the costs are covered by the patients and third party insurers who have had no opportunity to determine if such a level of services is necessary. Thus it is obvious why hospitals will prefer the exclusive contract arrangement under the current reimbursement arrangements.

A change in the reimbursement program whereby hospitals would share a single DRG payment (including the mandatory assignment fees) with any hospital-based physicians providing services under an exclusive contract arrangement, should force those hospitals that feel that it is necessary to provide rapid consultations in these specialties to purchase these services on a basis where they incur financial risk. Ideally, the hospitals would be interested in purchasing such services only to the extent to which they are appropriate for the level of services required by the community. In fact all hospitals will purchase such services because there is competitive pressure to provide such services, unless provisions are made to balance the competitive pressure with a potential financial gain where such services are not routinely provided. This is the inherent flaw in the current proposal to force all

hospital based physicians to accept a defined compensation - there will be no incentive to reduce the utilization of services, there will instead be only a limitation in income of hospital based physicians with a resulting deterioration in the quality and availability of their services to patients.

At the current time, there is little incentive for the hospitals to limit the use of ancilliary services, especially on an outpatient basis, since these hospital based physicians generally bill the patients directly, and the more services they provide (at whatever the cost) the more likely the hospitals are to attract highly profitable surgical patients and therefore the more likely it is that the hospital will attract additional members to its medical staff and so on. Competition between hospitals on the basis of the fees charged by their hospital based physicians is practically non-existent. As long as an individual contract groups' fees are not substantially higher than those charged by groups at surrounding hospitals, the hospital does not feel any need to reduce fees. In fact, the hospitals generally want the contract groups to charge the highest possible fees so as to insure that the members of the group are adequately compensated. Through this mechanism the hospital can increase the services provided to the medical staff and patients while incurring only minimal additional expense, and thereby attract additional members to join the medical staff, with a concomitant increase in the number of patients admitted to the hospital and eventually increased revenues. The bill for all this growth is paid by the patients and third party insurers. This will eventually result in an oversupply of expensive services and an increase in utilization to justify these services, an economic model with many other examples in the health care industry.

If hospital based physicians fees were included in the hospital's DRG payment, where there are exclusive contractual arrangements, then those hospitals which choose to have an exclusive contract arrangement would be forced to assume the cost, and therefore would have to determine if the increased revenues from maintaining such a contractual arrangement justified its expense. As an alternative, a hospital which does not supply anesthesiology, pathology and radiology services by exclusive contract loses the ability to guarantee the availability of services to all members of the medical staff without regard to economic need. Independent groups providing services will not remain physically present at a facility requiring only a small number of intra-operative consultations as it would not be cost effective.

A hospital that does not provide such services under contract would be at a competitive disadvantage when compared with a hospital that does provide such services under contract, unless, a hospital without such an exclusive contractual arrangement were allowed to keep the DRG payment (not including the mandatory fee assignment), and the now independent and competitive anesthesiologists, radiologists and pathologists were allowed to bill under Medicare Part B for their services. The additional monies available to these physicians through secondary insurance payments would encourage the provision of anesthesiology, pathology and radiology services at institutions without exclusive contracts, and yet would allow those hospitals with differing financial situations to make an individual determination as to the appropriate level of services.

The resulting fee competition should lower the fees for routine consultations, allow more individuals access to hospital facilities to provide specialized services to patients which may not currently be available under an exclusive contract, and help to insure that a level of service appropriate to each community is provided. For example, I currently provide pathology services to a number of small rural hospitals in Indiana and Illinois at a lower cost than these services are provided to patients here in

Evansville, Indiana, yet I am prevented from providing services to any patients who are hospitalized in Evansville, where my offices are located. I am prevented from offering my services (in this case a 48 hour turnaround time for a consultation report on a pathological specimen submitted to our laboratory rather than the 24 hour time standard in the hospitals here in Evansville) to physicians and patients because of the barriers erected by the hospitals in the form of exclusive contracts. Thus all patients in the hospitals in Evansville are being forced to purchase a high level of service in order to guarantee its availability to the few patients that need it, and those who would supply services at a lower price (such as myself) are unable to enter the marketplace because of preexisting exclusive contractual relationships.

In fact, the situation becomes even more remarkable if contractual relationships with Health Maintenance Organizations and Preferred Provider Organizations are taken into account. If I were to sucessfully negotiate a contract to provide services to members of a prepaid plan which utilized hospitals here in Evansville, I would be unable to provide services to inpatients because of the hospitals preexisting exclusive contractual relationships. Thus the exclusive contracts give the groups which hold them an inordinate influence in the marketplace. These contractual relationships prevent new competitors from entering the marketplace to provide pathology, anesthesiology and radiology services. Recently trained individuals, such as myself, are placed at a severe economic and competitive disadvantage and the status quo is maintained to the advantage of well entrenched individuals. I believe that the correct approach is to try to enact a payment provision such as the one I have proposed to enhance competition and improve access to services for patients.

There are many examples, although uncommon, of hospitals which do not have exclusive contracts for anesthesiology and radiology services. Riverside Community Hospital in Riverside California has two competing anesthesiology groups. Tucson Medical Center in Tucson Arizona has three competing radiology groups. Non-exclusive arrangements for pathology services are extremely rare, but not unprecendented. I believe that if such situations are carefully studied you will come to conclusions essentially similar to mine which are based on practice experiences both here in Indiana and Illinois and in southern California. Encouraging competition will not only benefit medicare recipients, but should benefit contractual relationships with major prepaid and managed care health insurance plans by reducing hospitals reliance on exclusive contractual relationships to provide anesthesiology, pathology and radiology services.

Thank-you for the opportunity to submit my written comments and I hope they are of assistance to the committee.